

*State of Iowa*

# **Iowa**

# **Administrative**

# **Code**

# **Supplement**

Biweekly  
August 26, 2020



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Published by the  
STATE OF IOWA  
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay or suspension imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

# **INSTRUCTIONS**

## **FOR UPDATING THE**

### **IOWA ADMINISTRATIVE CODE**

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone (515)281-3355 or (515)242-6873

#### **Utilities Division[199]**

Replace Chapter 11

#### **Human Services Department[441]**

Replace Chapters 78 and 79

#### **Professional Licensure Division[645]**

Replace Chapter 182

Replace Chapter 300

#### **Labor Services Division[875]**

Replace Analysis

Replace Chapters 3 and 4

Replace Chapter 10

Replace Chapter 26

Replace Chapter 61

Replace Chapter 71

Replace Chapter 90

Replace Chapter 155



## CHAPTER 11 ELECTRIC LINES

[Previously Ch 2, renumbered 10/20/75 Supp.]  
[Prior to 10/8/86, Commerce Commission[250]]

### **199—11.1(478) General information.**

**11.1(1) Purpose and authority.** The purpose of this chapter is to implement the requirements in Iowa Code chapter 478 and to establish procedures for electric franchise proceedings before the Iowa utilities board. This chapter shall apply to any person engaged in the construction, operation, and maintenance of electric transmission lines in Iowa.

**11.1(2) Iowa electrical safety code.** Overhead and underground electric line minimum safety requirements to be applied in installation, operation, and maintenance are found in 199—Chapter 25, Iowa electrical safety code.

**11.1(3) Date of filing.** A petition for franchise, and all other filings, shall be considered filed when accepted for filing by the board pursuant to 199—Chapter 14.

**11.1(4) Franchise, when required.** An electric franchise shall be required for the construction, operation, and maintenance of any electric line capable of operating at 69,000 volts (69 kV) or more outside of cities, except that a franchise is not required for electric lines located entirely within the boundaries of property owned by a person engaged in the transmission or distribution of electric power or an end user.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.2(478) Definitions.** For the administration and interpretation of this chapter, the following words and terms, when used in these rules, shall have the meanings indicated below:

*“Affected person”* means any person with a recorded legal right or interest in the property, including but not limited to a contract purchaser of record, a tenant occupying the property or possessing the property under a recorded lease, a record lienholder, and a record encumbrancer of the property. The term also includes persons in possession of or residing on the property and persons with unrecorded interests in property that have been identified through a good-faith effort of the electric company.

*“Board”* means the utilities board within the utilities division of the department of commerce.

*“Capable of operating”* means the standard voltage rating at which the electric line, wire, or cable can be operated consistent with the level of the insulators and the conductors used in construction of the electric line, wire, or cable based on manufacturer’s specifications, industry practice, and applicable industry standards.

*“Electric company”* means any person that proposes to construct, erect, maintain, or operate an electric line, wire, or cable in Iowa.

*“Person”* means individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity as defined in Iowa Code section 4.1(20).

*“Termini”* means the electrically functional end points of an electric line, without which it could not serve a public use. Examples of termini may include, but are not limited to, generating stations, substations, or switching stations.

*“Transmission line”* means any electric line, wire, or cable capable of operating at 69 kilovolts or more.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.3(478) Route selection.** The planning for a route that is the subject of a petition for franchise shall begin with routes that are near and parallel to roads, railroad rights-of-way, or division lines of land, according to the government survey, consistent with the provisions of Iowa Code section 478.18(2).

**11.3(1) Where deviations allowed.** Where a route planned near and parallel to roads, railroad rights-of-way, or division lines of land would contain segments making transmission line construction not practicable and reasonable, generally for engineering reasons, route deviation(s) may be proposed and accompanied by a proper evidentiary showing that the initial route or routes examined did not meet

practicable and reasonable standards pursuant to Iowa Code section 478.18(2). Deviations based on landowner preference or those that minimize interference with land may be permissible; however, the electric company must demonstrate that route planning began with a route or routes located near and parallel to roads, railroad rights-of-way, or division lines of land.

**11.3(2) *Distance from buildings.*** No transmission line shall be constructed outside of cities, except by agreement, within 100 feet of any dwelling, house or other building, except where the transmission line crosses or passes along a public highway or is located alongside or parallel with the right-of-way of any railroad company, consistent with the provisions of Iowa Code section 478.20. Construction of a new building within 100 feet of an existing transmission line shall be construed as “agreement” within the meaning of Iowa Code section 478.20.

**11.3(3) *Railroad crossings.*** Where these rules call for the consent or other showing of right from a railroad for a railroad crossing, an affidavit filed by an electric company which states that proper application for approval of the railroad crossing has been made, that a one-time crossing fee has been paid as provided for in rule 199—42.3(476), and that 35 days have passed since mailing of the application and payment with no claim of special circumstance or objection from the railroad will be accepted as a showing of consent for the crossing.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.4(478) *Informational meetings.*** Not less than 30 days or more than two years prior to filing a petition or related petitions requesting a franchise for a new transmission line with one or more miles of the total proposed route across privately owned real estate, the electric company shall hold an informational meeting in each county in which real property or real property rights will be affected. An informational meeting is required to be held in each county where property rights will be affected regardless of the length of the portion of the proposed transmission line in a county. The length of easements required for conductor and crossarm overhang of private property, even if no supporting structures are located on that property, shall be included in determining whether an informational meeting is required pursuant to Iowa Code section 478.2.

**11.4(1) *Facilities.*** Electric companies filing a petition for franchise shall be responsible for all negotiations and compensation for a suitable facility to be used for each informational meeting, including but not limited to a building or facility which is in substantial compliance with any applicable requirements of the Americans with Disabilities Act (ADA) Standards for Accessible Design, including both Title III regulations at 28 CFR Part 36, Subpart D, and the 2004 ADA Accessibility Guidelines (ADAAG) at 36 CFR Part 1191, Appendices B and D (as amended through September 2, 2020), where such a building or facility is reasonably available.

**11.4(2) *Location.*** The informational meeting location shall be reasonably accessible to all persons who may be affected by the granting of a franchise in that county or who have an interest in the proposed transmission line.

**11.4(3) *Personnel.*** At the informational meeting, qualified personnel representing the electric company shall make a presentation that includes the following information:

- a.* Utility service requirements and planning which have resulted in the proposed construction.
- b.* When the transmission line will be constructed.
- c.* In general terms, the physical construction, appearance and typical location of poles and conductors with respect to property lines.
- d.* In general terms, the rights which the electric company shall seek to acquire by easements.
- e.* Procedures to be followed in contacting affected persons with whom the electric company may seek specific negotiations in acquiring voluntary easements.
- f.* Methods and factors used in arriving at an offered price for voluntary easements including the range of cash amount of each component. An example of an offer sheet shall be included as part of the presentation.
- g.* The manner in which voluntary easement payments are made, including discussion of conditional easements, signing fees, and time of payment.

*h.* Other factors or damages which are not included in the easement but for which compensation is made, including features of interest to affected persons but not limited to computation of amounts and manner of payment.

*i.* If the undertaking is a joint effort by more than one electric company, all of the electric companies involved in the project shall be represented at the informational meeting by qualified personnel able to speak on the matters required by this subrule.

**11.4(4) Board approval.** An electric company proposing to schedule an informational meeting shall file a request with the board to schedule the informational meeting and shall include a proposed date and time for the informational meeting, an alternate date and time, and a general description of the proposed project and route. The board shall notify the electric company within ten days from the filing of the request whether the request is approved or alternate dates and times are required. Not less than 30 days prior to the informational meeting, the electric company shall file with the board the location of the informational meeting and a map of the proposed route that includes the notification corridor. Once a date and time for the informational meeting have been approved and not less than 14 days prior to the informational meeting, the electric company shall file a copy of the informational meeting presentation with the board.

**11.4(5) Notice of informational meeting.** Notice of each informational meeting shall be provided by certified mail, return receipt requested, to those persons listed on the tax assessment rolls as responsible for payment of real estate taxes on the property and persons in possession of or residing on the property within the notification corridor where the proposed transmission line will be located. The notification corridor includes any property over which the electric company may seek easements. Not less than 30 days prior to the date of the informational meeting, a copy of the notice shall be filed with the board and the notice shall be deposited in the U.S. mail by the electric company.

- a.* The notice shall include the following:
- (1) The name of the electric company;
  - (2) The electric company's principal place of business;
  - (3) The general description and purpose of the proposed project;
  - (4) The general nature of the right-of-way desired;
  - (5) The possibility that the right-of-way may be acquired by condemnation if approved by the board;
  - (6) A map showing the route of the proposed project and the notification corridor;
  - (7) A description of the process used by the board in making a decision on whether to approve a franchise, including the right to take property by eminent domain;
  - (8) A statement that affected persons have a right to be present at the informational meeting and to file objections with the board;
  - (9) Designation of the time and place of the meeting;
  - (10) The following statement: Persons with disabilities requiring assistive services or devices to observe or participate should contact the Utilities Board at (515)725-7300 in advance of the scheduled date to request accommodations; and
  - (11) A copy of the statement of damages as described in subrule 11.9(5).

*b.* The electric company shall cause the meeting notice, including the map, to be published once in a newspaper of general circulation in each county where the proposed line is to be located. The notice shall be published at least one week and not more than three weeks prior to the date of the meeting. Publication shall be considered notice to landowners and persons in possession of or residing on the property whose addresses are not known.

*c.* The electric company shall file prior to the informational meeting an affidavit that describes the good-faith effort the electric company undertook to locate the addresses of persons listed on the tax assessment rolls as responsible for payment of real estate taxes imposed on the property within the notification corridor where the proposed transmission line is to be located and those persons in possession of or residing on the property. The affidavit shall be signed by an officer of the electric company.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.5(478) Petition for a new franchise.** A single docket will be assigned to a proposed transmission line even if the transmission line will be located in more than one county. The electric company may request one franchise for the entire transmission line or may request separate franchises in each county where the proposed transmission line is to be located.

**11.5(1) *Petition and exhibits.*** A petition for a new franchise shall be filed on forms prescribed by the board, shall be notarized, and shall have all required exhibits attached. Exhibits in addition to those required by this rule may be attached when appropriate. The petition shall be attested to by an officer, official, or attorney with authority to represent the electric company. The following exhibits shall be filed with the petition:

*a. Exhibit A.* A legal description of the route. The description shall include the name of the county, the maximum and nominal voltages, the beginning point and endpoint of the transmission line, and whether the route is on public, private, or railroad right-of-way. In the case of multicounty projects, the description shall identify all counties involved in the total project and the termini located in other counties. When the route is in or adjacent to the right-of-way of a named road or a railroad, the exhibit shall specifically identify the road or railroad by name.

*b. Exhibit B.*

(1) A map showing the route of the transmission line drawn with reasonable accuracy considering the scale. The map may be to any scale appropriate for the level of detail to be shown but may not be smaller than one inch to the mile and shall be legible when printed on paper no larger than 11 by 17 inches. The following minimum information shall be provided:

1. The route of the transmission line which is the subject of the petition, including beginning point and endpoint and, when the transmission line is parallel to a road or railroad, which side the line is on. Line sections with multiple-circuit construction or underbuild shall be designated. The voltage at which other circuits are operated and ownership of other circuits or underbuild shall be indicated.

2. The name of the county, county and section lines, section numbers, and township and range numbers.

3. The location and identity of roads, named streams and bodies of water, and any other pertinent natural or man-made features or landmarks influencing the route.

4. The names and corporate limits of cities.

5. The names and boundaries of any public lands or parks, recreational areas, preserves or wildlife refuges.

6. All electric lines, including lines owned by the electric company, within six-tenths of a mile of the route, including the voltage at which the lines are operated, whether the lines are overhead or buried, and the names and addresses of the owners. Any electric lines to be removed or relocated shall be designated.

7. The location of railroad rights-of-way, including the names and addresses of the owners.

8. The location of airports or landing strips within one mile of the route, along with the names and addresses of the owners.

9. The location of pipelines used for the transportation of any solid, liquid, or gaseous substance, except water, within six-tenths of a mile of the route, along with the names and addresses of the owners.

10. The names and addresses of the owners of telephone, communication, or cable television lines within six-tenths of a mile of the route. The location of these lines need not be shown.

11. The names and addresses of the owners of rural water districts organized pursuant to Iowa Code chapter 357A that have facilities within six-tenths of a mile of the route. The location of these facilities need not be shown.

(2) A map of the entire route to be franchised if the route is located in more than one county or there is more than one map for a county.

*c. Exhibit C.* Technical information and engineering specifications describing typical materials, equipment and assembly methods as specified on forms provided by the board.

*d. Exhibit D.* The exhibit shall consist of a written text containing the following:

(1) An affidavit with an allegation and supporting information that the transmission line is necessary to serve a public use and represents a reasonable relationship to an overall plan of transmitting



electricity in the public interest. Additional substantiated allegations as may be required by Iowa Code section 478.3(2) shall also be included.

(2) If the route or any portion thereof is not near and parallel to roads or railroad rights-of-way, or along division lines of the lands, according to government surveys, an explanation of why such parallel routing is not practicable or reasonable.

(3) A statement regarding the availability of routes on an existing electric line right-of-way and an explanation of why this route was not selected.

(4) Any other information or explanation in support of the petition.

(5) If a new franchise must be sought for an existing transmission line, historical information regarding the prior franchise.

(6) A copy of the route study, if any, which was performed in determining the location of the proposed transmission line.

(7) The status of any other authorizations the electric company is required to obtain to construct the proposed transmission line.

*e. Exhibit E.* This exhibit is required only if the petition requests the right of eminent domain. This exhibit shall be in its final form prior to issuance of the official notice by the board and approval of the eminent domain notice required by Iowa Code section 478.6(2). The exhibit shall consist of a map of the route showing the location of each property for which the right of eminent domain is sought, and for each property:

(1) The legal description of the property.

(2) The legal description of the desired easement.

(3) A specific description of the easement rights being sought.

(4) The names and addresses of all affected persons.

(5) A map drawn to an appropriate scale showing the boundaries of the property, the boundaries and dimensions of the proposed easement, the location of all electric lines and supports within the proposed easement, the location of and distance to any building within 100 feet of the proposed transmission line, and any other features pertinent to the location of the transmission line, the supporting structures, or to the rights being sought.

(6) An affidavit affirming and describing the good-faith effort undertaken and the review of land records performed to identify all affected persons for all parcels over which the electric company is seeking eminent domain. The affidavit shall be signed by an attorney representing the electric company.

*f. Exhibit F.* The showing of notice to all persons identified in subparagraphs 11.5(1) "b"(6) through 11.5(1) "b"(11) and to the Iowa department of transportation. One copy of each letter of notification or one copy of the letter accompanied by a written statement listing all persons that were sent the notice, the date of mailing, and a copy of the map sent with the letters shall accompany the petition when it is filed with the board.

*g. Exhibit G.* The affidavit required by Iowa Code section 478.3(2) "c" on the holding of an informational meeting. Copies of the mailed notice letter and the published notice(s) of each informational meeting shall be attached to the affidavit. This exhibit is required only if an informational meeting was conducted.

*h. Exhibit H.* This exhibit is required only if the petition requests separate pole lines. This exhibit shall contain a request describing in detail the good cause for the board to authorize the construction of separate pole lines.

*i. Other exhibits.* The board may require filing of additional exhibits if further information on a particular project is deemed necessary.

**11.5(2) Notice of franchise petition.**

*a.* Whenever a petition for a new franchise is filed with the board, the board shall prepare a notice addressed to the citizens of each county through which the transmission line or lines extend. The electric company shall cause this notice to be published in a newspaper of general circulation in each county for two consecutive weeks. Proof of publication shall be filed with the board. This published notice shall constitute sufficient notice to all persons of the proceeding, except owners of record and persons

in possession of land to be crossed for which voluntary easements have not been obtained at the time of the first publication of the notice.

*b.* The electric company shall, in addition to publishing notice, serve notice in writing of the filing of the petition on the affected persons over which easements have not been obtained. The served notices shall be by ordinary mail, addressed to the last-known address, mailed not later than the first day of publication of the official notice. One copy of each letter of notification, or one copy of the letter accompanied by a written statement listing all persons to which it was mailed and the date of mailing, shall be filed with the board not later than five days after the date of second publication of the official notice. The electric company shall file a statement describing the action taken to ensure that the company has identified the names and addresses of all affected persons over which voluntary easements have not been obtained.

*c.* Published notices of petitions for franchise shall include provisions whereby interested persons can examine a map of the route. When the petition is filed, the electric company shall state whether a map is to be published with the notice or whether the notice is to include a telephone number and an address through which persons may request a map from the electric company at no cost. The map required by this paragraph need not be as detailed as the Exhibit B map but shall include at minimum the proposed route, section lines, section and township numbers, roads and railroads, city boundaries, and rivers and named bodies of water. A copy of this map shall be filed with the petition.

**11.5(3) Notice to other persons.** The electric company shall give written notice, by ordinary mail, mailed at the time the petition is filed with the board and accompanied by a map showing the route of the proposed electric transmission line, to the persons identified in subparagraphs 11.5(1) “*b*”(6) through 11.5(1) “*b*”(11) and to the Iowa department of transportation. One copy of each letter of notification or one copy of the letter accompanied by a written statement listing all persons that were sent the notice, the date of mailing, and a copy of the map sent with the letters shall accompany the petition when it is filed with the board.

**11.5(4) Eminent domain notice.** If an electric company is requesting the right of eminent domain over property as part of a petition for a new franchise, notice shall be provided pursuant to subrule 11.10(1).

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.6(478) Petition for an amendment to a franchise.** A petition for an amendment of a franchise shall include the same exhibits and information required for a new franchise as described in rule 199—11.5(478). Prior to the filing of any petition for an amendment to a franchise where an electric company must obtain new or additional interests in real property for a total of one route mile or more, informational meetings shall be held which meet the requirements of 199—11.4(478).

**11.6(1)** When a petition for amendment is required. A petition for amendment of a franchise shall be filed with the board for approval when the electric company is:

*a.* Increasing the operating voltage of any electric line, the level to which it is capable of operating, or to a voltage greater than that specified in the existing franchise.

*b.* Constructing an additional circuit which is capable of operating at a nominal voltage of 69 kV or more on a previously franchised line, where an additional circuit at such voltage is not authorized by the existing franchise.

*c.* Relocating a franchised line to a route different from that authorized by an existing franchise which requires that new or additional interests in property be obtained, or that new or additional authorization be obtained from highway or railroad authorities, for a total distance of one route mile or more, or for any relocations where the right of eminent domain is sought. An amendment is not required for relocations made pursuant to Iowa Code section 318.9(2).

**11.6(2)** When a new transmission line is proposed in a county where the electric company has a countywide franchise for all of the electric company’s transmission lines in a county, the new transmission line will be included in the countywide franchise as an amendment to the countywide franchise.

**11.6(3)** When an existing franchise in a county is proposed to be combined with another existing franchise in a county, a petition for an amendment of the franchise with the latest expiration date shall be filed to combine the transmission lines into one of the existing franchises.

**11.6(4)** An amendment to a franchise shall not be required for a voltage increase, additional circuit, or electric line relocation where such activity takes place entirely within the boundaries of property owned by an electric company or an end user.

**11.6(5)** Notice of a petition for franchise amendment. Notice of a petition for an amendment to a franchise shall be the same notice that is required for a petition for a new franchise as described in rule 199—11.5(478).

**11.6(6)** Eminent domain notice. If an electric company is requesting the right of eminent domain over property as part of a petition for amendment of a franchise, notice shall be provided pursuant to subrule 11.10(1).

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.7(478) Petition for the abbreviated franchise process.**

**11.7(1)** *Eligibility for abbreviated franchise process.* Petitions for an electric franchise or an amendment to a franchise may be filed pursuant to the abbreviated franchise process set forth in Iowa Code section 478.1(5) if the following requirements are met:

*a.* The project consists of the conversion, upgrading, or reconstruction of an existing electric line operating at 34.5 kV to a line capable of operating at 69 kV.

*b.* The project will be on substantially the same right-of-way as an existing 34.5 kV line. For purposes of this subrule, “substantially the same right-of-way” means that the new or additional interests in private property right-of-way will be required for less than one mile of the proposed project length. Easements required for conductor and crossarm overhang of private property or for anchor easements shall not be considered when determining the length of additional interests in private property right-of-way.

*c.* The project will have substantially the same effect on the underlying properties as the existing 34.5 kV line.

*d.* The completed transmission line will comply with the Iowa electrical safety code found in 199—Chapter 25.

*e.* The electric company does not request the power of eminent domain.

*f.* The electric company agrees to pay all costs and expenses of the franchise proceeding.

**11.7(2)** *Petition using abbreviated process.* A petition for a new franchise or an amendment to a franchise filed pursuant to the abbreviated franchise process set forth in Iowa Code section 478.1(5) shall be made on forms prescribed by the board, shall be notarized, and shall have all required exhibits attached. Exhibits in addition to those required by this subrule may be attached when appropriate. The exhibits required to be attached are as follows:

*a. Exhibit A.* A legal description of the route. The description shall include the name of the county, the maximum and nominal voltages, the beginning point and endpoint of the transmission line, and whether the route is on public, private, or railroad right-of-way. When the route is in or adjacent to the right-of-way of a named road or a railroad, the exhibit shall specifically identify the road or railroad by name. The description shall identify any termini located in other counties.

*b. Exhibit B.* A map showing the route of the transmission line drawn with reasonable accuracy considering the scale. The map may be to any scale appropriate for the level of detail to be shown but may not be smaller than one inch to the mile and must be legible when printed on paper no larger than 11 by 17 inches. The following minimum information shall be provided:

(1) The route of the transmission line which is the subject of the petition, including the beginning point and endpoint and, when the transmission line is parallel to a road or railroad, the side on which the line is located. Line sections with multiple-circuit construction or underbuild shall be designated. The voltage at which other circuits are operated and ownership of other circuits or underbuild shall be indicated.

(2) The name of the county, county and section lines, section numbers, and township and range numbers.

(3) The location and identity of roads, railroads, named streams and bodies of water, and any other pertinent natural or man-made features or landmarks influencing the route.

(4) The names and corporate limits of cities.

(5) If any deviation from the existing route is proposed, the original and proposed routes shall be shown and identified.

*c. Exhibit C.* Technical information and engineering specifications describing typical materials, equipment, and assembly methods as specified on forms provided by the board.

*d. Exhibit D.* The exhibit shall consist of written text containing the following:

(1) A listing of any existing franchises that would be terminated or amended in whole or in part by this petition, including the docket number, franchise number, date of issue, county of location, and to whom the franchise is granted.

(2) An allegation, with supporting testimony, that the project is eligible for the abbreviated franchise process.

(3) An allegation, with supporting testimony, that the project is necessary to serve a public use and represents a reasonable relationship to an overall plan of transmitting electricity in the public interest.

(4) An explanation for any deviations from the existing transmission line route.

(5) A statement regarding the availability of routes on an existing electric line right-of-way and an explanation of why this route was not selected.

*e. Exhibit E.* A statement that the right of eminent domain is not being requested.

*f. Exhibit F.* The exhibit shall consist of a showing of notice to other electric, pipeline, telephone, communication, cable television, rural water district, and railroad companies that have facilities which are crossed by or in shared right-of-way with the proposed transmission line.

*g. Exhibit G.* The exhibit shall consist of the form of notice to be mailed in accordance with subrule 11.7(3) to owners of and persons in possession of or residing on property where construction shall occur.

*h. Exhibit H.* This exhibit is required if the petition requests separate pole lines. This exhibit shall contain a request describing in detail the good cause for the board to authorize the construction of separate pole lines.

**11.7(3) Notice of franchise or amendment to franchise under abbreviated franchise process.**

*a.* One month prior to commencement of construction, an electric company shall provide written notice concerning the anticipated construction to the last-known address of the owners of record of the property where construction will occur and to persons in possession of or residing on such property. Notices may be served by ordinary mail, addressed to the last-known address of the owners of record of the property and to persons residing on such property. The electric company shall make a good-faith effort to identify and notify all owners of record and persons residing on the property.

*b.* The notice shall include the following information:

(1) A description of the purpose of the project and the nature of the work to be performed.

(2) A copy of the Exhibit B map.

(3) The estimated dates the construction or reconstruction will commence and end.

(4) The name, address, telephone number, and email address of a representative of the electric company who can respond to inquiries concerning the anticipated construction.

*c.* For the purposes of this rule, “construction” means physical entry onto private property by personnel or equipment for the purpose of rebuilding or reconstructing the transmission line.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.8(478) Petition for extension of franchise.**

**11.8(1) Petition and exhibits.** A petition for an extension of a franchise shall be made on forms prescribed by the board; shall be attested to by an officer, official, or attorney with authority to represent the electric company; and shall have all required exhibits attached. Exhibits in addition to those required by this rule may be attached when appropriate. For a transmission line that extends into more than

one county, the electric company may file a petition to combine the separate county franchises into one franchise for the entire transmission line.

*a. Exhibit A.* A legal description of the route. The description shall include the name of the county, the maximum and nominal voltages, the beginning point and endpoint of the transmission line, and whether the route is on public, private, or railroad right-of-way. When the route is in or adjacent to the right-of-way of a named road or a railroad, the exhibit shall specifically identify the road or railroad by name. The description shall identify any termini located in other counties.

*b. Exhibit B.* A map showing the route of the transmission line drawn with reasonable accuracy considering the scale. The map may be to any scale appropriate for the level of detail to be shown but may not be smaller than one inch to the mile and must be legible when printed on paper no larger than 11 by 17 inches. The following minimum information shall be provided:

(1) The route of the transmission line which is the subject of the petition, including beginning point and endpoint and, when the transmission line is parallel to a road or railroad, which side the line is on. Line sections with multiple-circuit construction or underbuild shall be designated. The voltage at which other circuits are operated and ownership of other circuits or underbuild shall be indicated.

(2) The name of the county, county and section lines, section numbers, and township and range numbers.

(3) The location and identity of roads, railroads, named streams and bodies of water, and any other pertinent natural or man-made features or landmarks influencing the route.

(4) The names and corporate limits of cities.

*c. Exhibit C.* Technical information and engineering specifications describing typical materials, equipment and assembly methods as specified on forms provided by the board.

*d. Exhibit D.* The exhibit shall consist of a written text containing the following:

(1) A listing of all existing franchises for which extension in whole or in part is sought, including the docket number, franchise number, date of issue, county of location, and to whom granted.

(2) A listing of all amendments to the franchises listed in subparagraph 11.8(1)“d”(1), including the docket number, amendment number, date of issue, and purpose of the amendment.

(3) A description of any substantial rebuilds, reconstructions, alterations, relocations, or changes in operation not included in a prior franchise or amendment proceeding.

(4) A description of any changes in ownership or operating and maintenance responsibility.

(5) An allegation, with supporting testimony, that the transmission line remains necessary to serve a public use and represents a reasonable relationship to an overall plan of transmitting electricity in the public interest.

(6) Any other information or explanation in support of the petition.

**11.8(2)** *Date for filing petition for extension.* A petition for an extension of a franchise shall be filed at least one year prior to expiration of the franchise. This requirement is not applicable to extensions of franchises that expire within one year of September 2, 2020. Extensions of existing countywide franchises are permitted; however, petitions to extend the franchises of separate transmission lines within a county by combining those transmission lines into a countywide franchise are not permitted using the franchise extension process.

**11.8(3)** *When petition for extension unnecessary.* An extension of franchise is unnecessary for an electric line which is capable of operating at 69 kV or more when the electric line has been permanently retired from operation and the board has been notified of the retirement. The notice to the board shall include the franchise number and issue date, the docket number, and, if the entire franchised line is not retired, a map showing the location of the portion retired.

**11.8(4)** *Petition for extension of countywide franchise.* A petition for an extension of a countywide franchise shall include all of the franchised lines owned by the electric company and within one county and a statement of whether the published notice will contain a legal description of the route or will include a telephone number and an address through which persons may request a map from the electric company at no cost. The map shall comply with the requirements in subrule 11.8(6). A copy of this map shall be filed with the petition.

**11.8(5) *Notice of petition for extension.*** Whenever a petition for an extension of a franchise is filed with the board, the board shall prepare a notice addressed to the citizens of each county through which the transmission line or lines extend. The electric company shall cause this notice to be published for two consecutive weeks in a newspaper of general circulation in each county where the proposed line is to be located. Proof of publication shall be filed with the board. This published notice shall constitute sufficient notice to all affected persons where the existing line is located.

**11.8(6) *Maps in published notice.*** Published notices of petitions for franchise shall include provisions whereby interested persons can examine a map of the route. When the petition is filed, the electric company shall state whether a map is to be published with the notice or whether the notice is to include a telephone number and an address through which persons may request a map from the electric company at no cost. The map required by this subrule need not be as detailed as the Exhibit B map but shall include at minimum the proposed route, section lines, section and township numbers, roads and railroads, city boundaries, and rivers and named bodies of water. A copy of this map shall be filed with the petition.

**11.8(7) *Notice to other persons.*** The electric company shall give written notice, by ordinary mail, mailed at the time the petition is filed with the board, accompanied by a map showing the route of the proposed transmission line, to the persons identified in subparagraphs 11.5(1)“b”(6) through 11.5(1)“b”(11) and to the Iowa department of transportation. One copy of each letter of notification or one copy of the letter accompanied by a written statement listing all persons that were sent the notice, the date of mailing, and a copy of the map sent with the letters shall accompany the petition when it is filed with the board.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

#### **199—11.9(478) Additional requirements.**

**11.9(1) *Forms.*** An electric company shall use the appropriate form or forms available on the board’s website when filing a petition, an amendment to an existing franchise, or an extension of an existing franchise. All filings shall be filed electronically in compliance with the board’s electronic filing system requirements in 199—Chapter 14 and shall be considered filed when accepted for filing into the board’s electronic filing system pursuant to 199—Chapter 14.

**11.9(2) *Temporary construction permits.*** An electric company may request a temporary construction permit, as allowed by Iowa Code section 478.31, on the board’s petition for franchise forms.

**11.9(3) *Segmental ownership.***

*a.* Petitions covering transmission line routes having segments of the total transmission line with different owners shall establish that the entire transmission line is necessary to serve a public use and represents a reasonable relationship to an overall plan of transmitting electricity in the public interest.

*b.* Petitions covering transmission line routes having segments of the total transmission line with different owners shall include documentation showing that the different owners have agreed to the construction being proposed in the petition.

**11.9(4) *Compliance with Iowa electrical safety code.*** If review of Exhibit C, or inspection of an existing electric line which is the subject of a franchise petition, finds noncompliance with 199—Chapter 25, the Iowa electrical safety code, no final action shall be taken by the board on the petition without a satisfactory showing by the electric company that the areas of noncompliance have been or will be corrected. Any disputed safety code compliance issues will be resolved by the board.

**11.9(5) *Statement of damage claims.***

*a.* A petition proposing transmission line construction shall not be acted upon by the board if the electric company does not file with the board a written statement as to how damages resulting from the construction of the transmission line shall be determined and paid.

*b.* The statement shall contain the following information: the type of damages which will be compensated for, how the amount of damages will be determined, the procedures by which disputes may be resolved, the manner of payment, and the procedures that the affected persons are required to follow to obtain a determination of damages.

c. The statement shall be amended as necessary to reflect changes in the law, company policy, or the needs of a specific project.

d. A copy of this statement shall be mailed with the notice of informational meeting as provided for in Iowa Code section 478.2(3). Where no informational meeting is required, a copy shall be provided to each affected person prior to entering into negotiations for payment of damages.

e. Nothing in this rule shall prevent a person from negotiating with the electric company for terms which are different from, more specific than, or in addition to those in the statement filed with the board. [ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

#### **199—11.10(478) Notices.**

**11.10(1) Notice of eminent domain proceedings.** If a petition for a franchise or amendment of franchise seeks the right of eminent domain, the electric company shall, in addition to publishing a notice of hearing, serve the written notice required by Iowa Code section 478.6(2) on the landowners and any affected person for all parcels over which eminent domain is sought. The eminent domain notice shall be filed with the board for approval. Service shall be by certified U.S. mail, return receipt requested, and addressed to the person's last-known address. This notice shall be mailed no later than the first day of publication of the official notice of hearing concerning the petition.

a. The notice of eminent domain proceedings shall include the following:

(1) A copy of the Exhibit E filed with the board for the affected property.

(2) The proposed route of the electric transmission line.

(3) The eminent domain rights being sought over the property.

(4) The date, time and location of the hearing and a description of the hearing procedures. The description of the hearing procedures shall include the website address for the board's electronic filing system and contact information of the board's customer service section.

(5) The statement of individual rights required pursuant to Iowa Code section 6B.2A(1).

b. Not less than five days prior to the date of hearing, the electric company shall file with the board the return receipt for the certified notice.

#### **11.10(2) Notice of franchised line construction.**

a. Within 90 days after completion of a transmission line construction or reconstruction project authorized by a franchise or amendment to franchise, the holder of the franchise shall notify the board in writing of the completion. The notice shall include the franchise and docket numbers and the date the franchise was issued.

b. If the project is not completed within two years after the date of issuance of the franchise or amendment to franchise, the electric company shall file a progress report regarding construction of the transmission line.

c. If construction of the transmission line authorized by a franchise has not commenced within two years of the date the franchise is granted, or within two years after final disposition of judicial review of a franchise order or of condemnation proceedings, the franchise shall be forfeited unless the electric company petitions the board for an extension of time to commence construction. The board may grant the extension if good cause is shown for the failure to commence construction.

**11.10(3) Notice of transfer or assignment of franchise.** The holder of a franchise shall notify the board in writing, when transferring any franchise or portion of a franchise, stating the applicable franchise number and docket number which are affected and a description of the route of the transmission line when less than the total franchised line is affected, together with the name of the transferee and date of transfer, not more than 30 days after the effective date of the transfer.

**11.10(4) Notice of relocations not requiring an amendment to franchise.** Whenever a transmission line under franchise is relocated in a manner that does not require an amendment to franchise, the holder of the franchise shall notify the board in writing of the relocation, stating the franchise and docket numbers and date of franchise issuance for the affected transmission line, and providing revised Exhibits A and B that reflect the changes in the route, not more than 30 days after the commencement of the relocation.

**11.10(5) Notice of transmission line reconstruction not requiring an amendment to franchise.** Whenever a transmission line is reconstructed with different materials or specifications than those that appear on the most recent Exhibit C and an amendment to franchise is not required, the holder of the franchise shall notify the board in writing of the reconstruction, stating the franchise and docket numbers and date of franchise issuance for the affected transmission line, and providing a revised Exhibit C that reflects the changes in the manner of construction, not more than 30 days after the commencement of the reconstruction.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.11(478) Common and joint use.**

**11.11(1) Common use construction.** Whenever an overhead electric line capable of operating at 69 kV or more is built or rebuilt on public road rights-of-way located outside of cities, all parallel overhead electric supply circuits on the same road right-of-way shall be attached to the same or common line of structures unless the board authorizes, for good cause shown, the construction of separate pole lines.

**11.11(2) Relocating lines.** When a transmission line is to be constructed in a location occupied by an electric line or a communication line, the expense of relocating the existing line shall be borne by the electric company proposing the new transmission line. The electric company proposing the new transmission line shall not be required to pay any part of the used life of the existing line, but shall pay only the nonbetterment expense of relocating the existing line.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.12(478) Termination of franchise petition proceedings.**

**11.12(1) Termination of docket.** Upon notice to the board by an electric company that a franchise petition or petition for amendment of a franchise is withdrawn, the docket shall be closed by board order.

**11.12(2) Failure to respond.** If an electric company fails to respond to written notification by the board, to correct an incomplete or deficient franchise petition, or to publish the official notice after the form of notice is provided by the board, the board may dismiss the petition as abandoned. If dismissal would cause an existing transmission line to be without a franchise, the board may also pursue imposition of civil penalties.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

**199—11.13(478) Fees and expenses.** The electric company shall pay the actual cost incurred by the board attributable to the processing, investigation, and inspection related to a petition requesting an electric franchise, an amendment to an electric franchise, or an extension of an electric franchise.

[ARC 5121C, IAB 7/29/20, effective 9/2/20; see Delay note at end of chapter]

These rules are intended to implement Iowa Code chapter 478.

[Filed prior to 7/4/51, amended 9/24/65, 12/14/65]

[Filed 10/8/75—published 10/20/75]

[Filed 8/6/76, Notice 4/5/76—published 8/23/76, effective 9/27/76]

[Filed 4/10/79, Notice 5/3/78, 8/23/78—published 5/2/79, effective 6/6/79]

[Filed 8/29/80, Notice 6/25/80—published 9/17/80, effective 10/22/80]

[Filed 2/12/82, Notice 10/28/81—published 3/3/82, effective 4/7/82]

[Filed emergency 6/28/82—published 7/21/82, effective 6/28/82]

[Filed 10/5/84, Notice 7/18/84—published 10/24/84, effective 11/28/84]

[Filed emergency 9/18/86—published 10/8/86, effective 9/18/86]

[Filed 10/16/87, Notice 8/26/87—published 11/4/87, effective 12/9/87]

[Filed 7/1/93, Notice 12/9/92—published 7/21/93, effective 8/25/93]

[Filed 7/1/93, Notice 3/17/93—published 7/21/93, effective 8/25/93]

[Filed 4/21/95, Notice 10/26/94—published 5/10/95, effective 6/14/95]

[Filed 3/20/98, Notice 10/22/97—published 4/8/98, effective 5/13/98]

[Filed 10/13/99, Notice 5/19/99—published 11/3/99, effective 12/8/99]

[Filed 4/12/02, Notice 3/6/02—published 5/1/02, effective 6/5/02]

[Filed 6/21/02, Notice 5/15/02—published 7/10/02, effective 8/14/02]



[Filed 4/24/03, Notice 12/11/02—published 5/14/03, effective 6/18/03]

[Filed 9/24/04, Notice 8/18/04—published 10/13/04, effective 11/17/04]

[Filed 4/18/08, Notice 3/12/08—published 5/7/08, effective 6/11/08]

[Editorial change: IAC Supplement 9/10/08]

[Filed 10/31/08, Notice 4/9/08—published 11/19/08, effective 12/24/08]

[Filed ARC 8435B (Notice ARC 7859B, IAB 6/17/09; Amended Notice ARC 8012B, IAB 7/29/09),  
IAB 12/30/09, effective 2/3/10]

[Editorial change: IAC Supplement 12/29/10]

[Filed ARC 5121C (Notice ARC 4776C, IAB 11/20/19), IAB 7/29/20, effective 9/2/20]<sup>1</sup>

<sup>1</sup> September 2, 2020, effective date of Chapter 11 [ARC 5121C] delayed 70 days by the Administrative Rules Review Committee at its meeting held August 11, 2020.



CHAPTER 78  
AMOUNT, DURATION AND SCOPE OF  
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

**441—78.1(249A) Physicians' services.** Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

**78.1(1)** Payment will not be made for:

*a.* Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

*b.* Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

*c.* Treatment of certain foot conditions as specified in 78.5(2) "*a*," "*b*," and "*c*."

*d.* Acupuncture treatments.

*e.* Rescinded 9/6/78.

*f.* Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

*g.* Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the IME medical services unit or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the IME medical services unit and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

*h.* Elective, non-medically necessary cesarean section (C-section) deliveries.

**78.1(2)** Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

*a.* Drugs are covered as provided by rule 441—78.2(249A).

*b.* Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

**78.1(3)** Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

**78.1(4)** For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

**78.1(5)** The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

**78.1(6)** Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

**78.1(7)** No payment shall be made for the services of a private duty nurse.

**78.1(8)** Payment for mileage shall be the same as that in effect in part B of Medicare.

**78.1(9)** Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

*a.* Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

*b.* When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

*c.* Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

*d.* Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13) "e." On-site supervision of the physician is not required for these services.

**78.1(10)** Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

**78.1(11)** Rescinded, effective 8/1/87.

**78.1(12)** Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

**78.1(13)** Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

*a.* Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

*b.* An auxiliary person is considered to be an employee of the physician if the physician:

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

*c.* Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

*d.* Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician

has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

**78.1(14)** Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

**78.1(15)** The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

**78.1(16)** No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

*a.* The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

*b.* The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

*c.* The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

*d.* The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

*e.* The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

*f.* At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs

not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

*g.* The information in paragraphs “*b*” through “*f*” shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual’s choice present when consent is obtained.

*h.* The consent form described in paragraph 78.1(16) “*b*” shall be attached to the claim for payment and shall be signed by:

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

*i.* Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

*j.* Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

**78.1(17)** Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

*a.* The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term.

*b.* The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

*c.* The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

*d.* The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

**78.1(18)** Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(4))

**78.1(19)** Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the IME medical services unit and the department. If not so approved by the IME medical services unit, payment will not be made under the



program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

**78.1(20) Transplants.**

*a.* Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1) "f")

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

*b.* Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

*c.* All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

*d.* Payment will not be made for any transplant not specifically listed in paragraph “a.”

**78.1(21)** Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.1(22)** Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

*a.* If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

*b.* If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

**78.1(23)** EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

**78.1(24)** Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

*a.* Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

*b.* Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

*c.* Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

*d.* Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

**78.1(25)** Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0846C, IAB 7/24/13, effective 7/1/13; ARC 1052C, IAB 10/2/13, effective 11/6/13; ARC 1297C, IAB 2/5/14, effective 4/1/14; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.2(249A) Prescribed outpatient drugs.** Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

**78.2(1) *Qualified prescriber.*** All drugs are covered only if prescribed by a legally qualified practitioner. Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

**78.2(2) *Prescription required.*** As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription, a prescription shall be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

**78.2(3) *Qualified source.*** All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

**78.2(4) *Prescription drugs.*** Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

*a.* Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

*b.* Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes.

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

**78.2(5) *Nonprescription drugs.***

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg  
Acetaminophen elixir 160 mg/5 ml  
Acetaminophen solution 100 mg/ml  
Acetaminophen suppositories 120 mg  
Artificial tears ophthalmic solution  
Artificial tears ophthalmic ointment  
Aspirin tablets 81 mg, chewable  
Aspirin tablets 81 mg, 325 mg, and 650 mg oral  
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg  
Aspirin tablets, buffered 325 mg  
Bacitracin ointment 500 units/gm  
Benzoyl peroxide 5%, gel, lotion  
Benzoyl peroxide 10%, gel, lotion  
Cetirizine hydrochloride liquid 1 mg/ml  
Cetirizine hydrochloride tablets 5 mg  
Cetirizine hydrochloride tablets 10 mg  
Chlorpheniramine maleate tablets 4 mg  
Clotrimazole vaginal cream 1%  
Diphenhydramine hydrochloride capsules 25 mg  
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml  
Epinephrine racemic solution 2.25%  
Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)  
Ferrous sulfate tablets 325 mg  
Ferrous sulfate elixir 220 mg/5 ml  
Ferrous sulfate drops 75 mg/0.6 ml  
Ferrous gluconate tablets 325 mg  
Ferrous fumarate tablets 325 mg  
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid  
Ibuprofen suspension 100 mg/5 ml  
Ibuprofen tablets 200 mg  
Insulin  
Lactic acid (ammonium lactate) lotion 12%  
Levonorgestrel 1.5 mg  
Loperamide hydrochloride liquid 1 mg/5 ml  
Loperamide hydrochloride liquid 1 mg/7.5 ml  
Loperamide hydrochloride tablets 2 mg  
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg  
Magnesium hydroxide suspension 400 mg/5 ml  
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable  
Miconazole nitrate cream 2% topical and vaginal  
Miconazole nitrate vaginal suppositories, 100 mg  
Mineral products with prior authorization  
Neomycin-bacitracin-polymyxin ointment  
Nicotine gum 2 mg, 4 mg  
Nicotine lozenge 2 mg, 4 mg  
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day  
Pediatric oral electrolyte solutions  
Permethrin lotion 1%  
Polyethylene glycol 3350 powder  
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg  
Pseudoephedrine hydrochloride liquid 30 mg/5 ml  
Pyrethrins-piperonyl butoxide liquid 0.33-4%  
Pyrethrins-piperonyl butoxide shampoo 0.3-3%  
Pyrethrins-piperonyl butoxide shampoo 0.33-4%  
Salicylic acid liquid 17%  
Senna tablets 187 mg  
Sennosides-docusate sodium tablets 8.6 mg-50 mg  
Sennosides syrup 8.8 mg/5 ml  
Sennosides tablets 8.6 mg  
Sodium bicarbonate tablets 325 mg  
Sodium bicarbonate tablets 650 mg  
Sodium chloride hypertonic ophthalmic ointment 5%  
Sodium chloride hypertonic ophthalmic solution 5%  
Tolnaftate 1% cream, solution, powder  
Vitamins, single and multiple with prior authorization  
Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

*b.* Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

**78.2(6)** *Quantity prescribed.*

*a.* *Quantity prescribed.* When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

*b.* *Prescription refills.*

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are not allowed. A request specific to each medication is required.

2. All prescription refills shall be initiated by a request at the time of each fill by the prescriber, Medicaid member or person acting as an agent of the member, based on continued medical necessity.

**78.2(7)** *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

**78.2(8)** *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not

required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.3(249A) Inpatient hospital services.** Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

**78.3(1)** Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

**78.3(2)** No payment will be approved for private duty nursing.

**78.3(3)** Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

**78.3(4)** Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

**78.3(5)** Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4) “b”(1) to (10) except for 78.2(4) “b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

*a.* Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4) “b”(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

*b.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**78.3(6)** Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

**78.3(7)** Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient’s condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient’s diagnosis or treatment.

**78.3(8)** Rescinded IAB 2/6/91, effective 4/1/91.

**78.3(9)** Payment will be made for sterilizations in accordance with 78.1(16).

**78.3(10)** Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

*a. Recipient selection and education.*

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

*b. Staffing and resource commitment.*

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.

Hepatology.

Immunology.

Infectious diseases.

Nephrology.

Neurology.

Pathology.

Pediatrics.

Psychiatry.

Pulmonary medicine.

Radiology.

Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. *Experience and survival rates.*

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success



and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

*d. Organ procurement.* The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

*e. Maintenance of data, research, review and evaluation.*

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

*f. Application procedure.* A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

*g. Review and approval of facilities.* An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

**78.3(11)** Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

**78.3(12)** Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “a” and “r” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

**78.3(13)** Payment for patients in acute hospital beds who are determined by the IME medical services unit to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

**78.3(14)** Payment for patients in acute hospital beds who are determined by the IME medical services unit to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

**78.3(15)** Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

**78.3(16)** Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit

for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

*b.* Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.  
 (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

**78.3(17)** Rescinded IAB 8/9/89, effective 10/1/89.

**78.3(18)** Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

**78.3(19)** Rescinded IAB 10/8/97, effective 12/1/97.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.4(249A) Dentists.** Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

**78.4(1) Preventive services.** Payment shall be made for the following preventive services:

*a.* Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

**78.4(2) Diagnostic services.** Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

**78.4(3) Restorative services.** Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow

restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

**78.4(4) Periodontal services.** Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(3) "a"(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

**78.4(5) Endodontic services.** Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference 78.28(3)“c”)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

**78.4(6) Oral surgery—medically necessary.** Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician’s reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

**78.4(7) Prosthetic services.** Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months’ postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(3) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(3) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period are payable.

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

**78.4(8) Orthodontic procedures.** Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(3) "c")

*b.* Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

*c.* Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

**78.4(9) *Adjunctive general services.*** Payment may be made for the following:

*a.* Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

*b.* Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

*c.* Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

*d.* Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

*e.* Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

*f.* Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

*g.* Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

**78.4(10) *Orthodontic services to members 21 years of age or older.*** Orthodontic procedures are not covered for members 21 years of age or older.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.5(249A) Podiatrists.** Payment will be approved only for certain podiatric services.

**78.5(1)** Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

- a.* Durable plantar foot orthotic.
- b.* Plaster impressions for foot orthotic.
- c.* Molded digital orthotic.
- d.* Shoe padding when appliances are not practical.
- e.* Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
- f.* Rams horn (hypertrophic) nails.
- g.* Onychomycosis (mycotic) nails.

**78.5(2)** Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:



a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

**78.5(3)** Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2) “c.” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.6(249A) Optometrists.** Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

**78.6(1) Payable professional services.** Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through seven years of age.

3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or

chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
- (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
- (5) Soft contact lenses and replacements are allowed when medically necessary.

**78.6(2) *Ophthalmic materials.*** Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a. Corrected curve lenses, unless clinically contraindicated.
- b. Standard plastic, plastic and metal combination, or metal frames.
- c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

**78.6(3) *Reimbursement.*** The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

- a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

- b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

**78.6(4) *Prior authorization.*** Prior authorization is required for the following:

- a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

- b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

- c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

- d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

- e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference 78.28(4))

**78.6(5) *Noncovered services.*** Noncovered services include, but are not limited to, the following services:

- a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

- b. Glasses for occupational eye safety.
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Sunglasses.
- f. Progressive bifocal or trifocal lenses.

**78.6(6) *Therapeutically certified optometrists.*** Rescinded IAB 9/5/12, effective 11/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.7(249A) Opticians.** Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(4))

**78.7(1) to 78.7(3)** Rescinded IAB 4/3/02, effective 6/1/02.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.8(249A) Chiropractors.** Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

**78.8(1) *Covered services.*** Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

**78.8(2) *Indications and limitations of coverage.***

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

\* NEC means not elsewhere classified.

*b.* The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

*c.* CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

**78.8(3) Documenting X-ray.** An X-ray must document the primary regions of subluxation being treated by CMT.

*a.* The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

*b.* The X-ray films shall be labeled with the patient’s name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient’s clinical record.

*c.* Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which



major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—78.9(249A) Home health agencies.** Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member’s residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) “a” may be provided in settings other than the member’s residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member’s community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician’s signature and date on a plan of treatment.

**78.9(1) Treatment plan.** A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
  - (1) Dates of prior hospitalization.
  - (2) Dates of prior surgery.
  - (3) Date last seen by a physician.
  - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
  - (5) Prognosis.
  - (6) Functional limitations.
  - (7) Vital signs reading.
  - (8) Date of last episode of instability.
  - (9) Date of last episode of acute recurrence of illness or symptoms.
  - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's signature and date. The plan of care must be signed and dated by the physician

before the claim for service is submitted for reimbursement.

**78.9(2) *Supervisory visits.*** Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

**78.9(3) *Skilled nursing services.*** Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

**78.9(4) *Physical therapy services.*** Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established

by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

**78.9(5) Occupational therapy services.** Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

**78.9(6) Speech therapy services.** Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

**78.9(7) Home health aide services.** Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

*a.* The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

*b.* The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

*c.* Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

**78.9(8) Medical social services.** Rescinded IAB 3/29/17, effective 5/3/17.

**78.9(9)** *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide

sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.
- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.

- (5) Extended hospitalization and separation from other family members.
  - (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
  - (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
  - (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
  - (9) Discharge or release against medical advice before 36 hours of age.
  - (10) Nutrition or feeding problems.
- e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:
- (1) Child or sibling victim of child abuse or neglect.
  - (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
  - (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
  - (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
  - (5) Malignancies such as leukemia or carcinoma.
  - (6) Severe injuries necessitating treatment or rehabilitation.
  - (7) Disruption in family or peer relationships.
  - (8) Suspected developmental delay.
  - (9) Nutritional deficiencies.

**78.9(10)** *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

- 1. Respite care, which is a temporary intermission or period of rest for the caregiver.
- 2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
- 3. Services provided to other persons in the member's household.
- 4. Services requiring prior authorization that are provided without regard to the prior authorization process.
- 5. Transportation services.
- 6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include

nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

*b. Requirements.*

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(10))

**78.9(11) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.**

**78.10(1) General payment requirements.** Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

*a.* DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

*b.* The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the

expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5) "k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) "n" for prior authorization requirements.

**78.10(2) Durable medical equipment.** DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

*a.* Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5) “f” for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

*b.* The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5) “d” for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5) “g” and “j” for prior authorization requirements.

Commode, shower commode chair. See 78.10(5) “j” for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5) “a” for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5) “c” for prior authorization requirements.

Insulin infusion pump. See 78.10(5) “b” and 78.10(5) “e” for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5) “i” for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2) “a” and 78.10(2) “c.”

Patient lift. See 78.10(5) “h” for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.



Seat lift chair.

Speech generating device. See 78.10(5) “f” for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member’s condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;
3. Positioning accessories;
4. Specialized skin protection seat and back cushions; and
5. Anti-rollback devices.

(3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:

1. Lap belt or safety belt;

2. Battery charger, single mode;
3. Complete set of tires/wheels and casters, any type;
4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
  - For standard duty, seat width and/or depth greater than 20 inches;
  - For heavy duty, seat width and/or depth greater than 22 inches;
  - For very heavy duty, seat width and/or depth greater than 24 inches;
  - EXCEPTION: For extra heavy duty, there is no separate billing;
9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
  - For standard duty, seat width and/or depth greater than 20 inches;
  - For heavy duty, seat width and/or depth greater than 22 inches;
  - For very heavy duty, seat width and/or depth greater than 24 inches;
  - EXCEPTION: For extra heavy duty, there is no separate billing;
10. Non-expandable controller or standard proportional joystick (integrated or remote); and
11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:

1. Shoulder harness/straps or chest straps/vest;
2. Elevating legrest;
3. Angle adjustable footplates;
4. Adjustable height armrests; and
5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

(5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.

**78.10(3) Prosthetic devices.** Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

*a.* Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

*b.* The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

- (1) Artificial eyes.
- (2) Artificial limbs.
- (3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.
- (4) Hearing aids. See rule 441—78.14(249A).
- (5) Orthotic devices. See 78.10(3) "c" for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

**78.10(4) Medical supplies.** Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) "e" for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5) "m" for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

**78.10(5) Prior authorization requirements.** Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time per day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with

expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.11(249A) Ambulance service.** Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

**78.11(1)** Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate

facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

**78.11(2)** The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

**78.11(3)** When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

**78.11(4)** Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

**78.11(5)** In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.12(249A) Behavioral health intervention.** Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

**78.12(1) Definitions.**

*"Behavioral health intervention"* means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

*"Licensed practitioner of the healing arts"* or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

*"Managed care organization"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

*"Mental disorder"* means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced

movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

**78.12(2) Covered services.**

*a. Service setting.*

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

*b. Crisis intervention.* Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

*c. Behavior intervention.* Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

*d. Family training.* Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

*e. Skill training and development.* Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and
3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

**78.12(3) Excluded services.**

*a.* Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

*b.* Respite, day care, education, and recreation services are not covered under behavioral health intervention.

**78.12(4) Coverage requirements.** Medicaid covers behavioral health intervention only when the following conditions are met:

*a.* A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

*b.* The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

*c.* For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

*d.* The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).



**78.12(5) Approval of plan.** The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

*a. Initial plan.* The initial services implementation plan must meet all of the following criteria:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

*b. Subsequent plans.* The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

**78.12(6) Medical necessity.** Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

*a.* Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

*b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

*c.* The least costly type of service that can reasonably meet the medical needs of the member; and

*d.* In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

**441—78.13(249A) Nonemergency medical transportation.** The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

**78.13(1) Covered services.** Nonemergency medical transportation services available are limited to:

*a.* The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

**78.13(2) Exclusions.** Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

**78.13(3) Conditions and limitations on covered services.** Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

*b. No free transportation alternatives available.* Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

*c. No member transportation alternatives available.* Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

*d. Limitations on reimbursement for meals.* Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

*e. Limitations on reimbursement for lodging expenses.* Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

*f. Closest medical provider.* Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

*g. Member scheduling obligations.* Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

*h. Abusive behavior.* Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

*i. Member claim submission.* Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

**78.13(4) Grievance procedure.** The broker shall establish an internal grievance procedure for members and transportation providers.

- a.* Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b.* Transportation providers.
  - (1) Consent for state fair hearing.
    - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
    - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
    - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
  - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“*b*,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

**441—78.14(249A) Hearing aids.** Payment shall be approved for a hearing aid and examinations subject to the following conditions:

**78.14(1) Physician examination.** The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a.* Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.
- b.* Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

**78.14(2) Audiological testings.** A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

**78.14(3) Hearing aid evaluation.** A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

**78.14(4) Hearing aid selection.** A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

**78.14(5) Travel.** When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

**78.14(6) Purchase of hearing aid.** The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a.* A child needs the aid for speech development,

- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

**78.14(7) Payment for hearing aids.**

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8008B, IAB 7/29/09, effective 8/1/09; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.15(249A) Orthopedic shoes.** Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

**78.15(1) Definitions.**

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- 2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

*“Insert”* means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

**78.15(2) Prescription.** The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

**78.15(3) Diagnosis.** The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

*a.* A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

*b.* Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

**78.15(4) Frequency.** Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.16(249A) Community mental health centers.** Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

**78.16(1)** Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

*a.* Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

*b.* Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

**78.16(2)** The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1) "b"(1).

**78.16(3)** The peer review process and related activities, as described under subparagraph 78.16(1) "b"(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

**78.16(4)** Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

**78.16(5)** At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

**78.16(6)** Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6) "b."

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

*d.* Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

**78.16(7)** Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

*a. Program documentation.* Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs “c” to “h” below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

*b. Program standards.* Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified



occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

*c. Program services.* Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

*d. Admission criteria.* Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

- (1) The patient is at risk for exclusion from normative community activities or residence.
- (2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
- (3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

*e. Individual treatment plan.* Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs

with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

*f. Discharge criteria.* Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

*g. Coordination of services.* Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

*h. Stable milieu.* The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

*i. Chronic mental illness.* Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

This rule is intended to implement Iowa Code section 249A.4.

**441—78.17(249A) Physical therapists.** Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

**441—78.18(249A) Screening centers.** Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

**78.18(1)** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**78.18(2)** Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

**78.18(3)** Periodicity schedules for health, hearing, vision, and dental screenings.

*a.* Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

*b.* Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

*c.* Interperiodic screenings will be approved as medically necessary.

**78.18(4)** When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

**78.18(5)** When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

**78.18(6)** Rescinded IAB 12/3/08, effective 2/1/09.

**78.18(7)** Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

**78.18(8)** Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.19(249A) Rehabilitation agencies.**

**78.19(1)** *Coverage of services.*

*a. General provisions regarding coverage of services.*

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.
2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

*b. Physical therapy services.*

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

*c. Occupational therapy services.*

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b" (7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b" (8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

*d. Speech therapy services.*

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and



swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

**78.19(2) General guidelines for plans of treatment.**

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).

(2) Prior teaching, training, or counseling provided.

(3) The medical necessity of the rendered services.

(4) The identification of specific services and goals.

- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0994C, IAB 9/4/13, effective 11/1/13]

**441—78.20(249A) Independent laboratories.** Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.21(249A) Rural health clinics.** Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

**78.21(1) Utilization review.** Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.21(2) Risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

*a.* If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

*b.* If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

**78.21(3) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.22(249A) Family planning clinics.** Payments will be made on a fee schedule basis for services provided by family planning clinics.

**78.22(1)** Payment will be made for sterilization in accordance with 78.1(16).

**78.22(2)** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.23(249A) Other clinic services.** Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

**78.23(1) Sterilization.** Payment will be made for sterilization in accordance with 78.1(16).

**78.23(2) Utilization review.** Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.23(3) Risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

*a.* If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

*b.* If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

**78.23(4) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.24(249A) Psychologists.** Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

**78.24(1)** Payment for covered services provided by the psychologist shall be made on a fee for service basis.

*a.* Payment shall be made only for time spent in face-to-face consultation with the client.

*b.* Time spent with clients shall be rounded to the quarter hour.

**78.24(2)** Payment will be approved for the following psychological procedures:

*a.* Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

*b.* Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

*c.* A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

*d.* Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

*e.* Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

*f.* Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

*g.* Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

**78.24(3)** Payment will not be approved for the following services:

*a.* Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

*b.* Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

*c.* Psychological examinations employing unusual or experimental instrumentation.

*d.* Individual and group psychotherapy without specification of condition, symptom, or complaint.

*e.* Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

**78.24(4)** Rescinded IAB 10/12/94, effective 12/1/94.

**78.24(5)** The following services shall require review by a consultant to the department.

*a.* Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

*b.* Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

**441—78.25(249A) Maternal health centers.** Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment

will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

**78.25(1) Provider qualifications.**

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

**78.25(2) Services covered for all pregnant women.** Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3) "b."

**78.25(3) Enhanced services covered for women with high-risk pregnancies.** Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

- c. Nutrition assessment and counseling, which shall include:
  - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
  - (2) Ongoing nutritional assessment.
  - (3) Development of an individualized nutritional care plan.
  - (4) Referral to food assistance programs if indicated.
  - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
  - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
  - (2) A profile of the client's family composition, patterns of functioning and support systems.
  - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
  - (1) Assessment of mother's health status.
  - (2) Physical and emotional changes postpartum.
  - (3) Family planning.
  - (4) Parenting skills.
  - (5) Assessment of infant health.
  - (6) Infant care.
  - (7) Grief support for unhealthy outcome.
  - (8) Parenting of a preterm infant.
  - (9) Identification of and referral to community resources as needed.

**78.25(4) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.26(249A) Ambulatory surgical center services.** Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

**78.26(1)** Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

**78.26(2)** Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

**78.26(3)** The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

**78.26(4)** Limits on covered services.

- a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.27(249A) Home- and community-based habilitation services.** Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.27(1) Definitions.**

*“Adult”* means a person who is 18 years of age or older.

*“Assessment”* means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

*“Benefits education”* means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

*“Care coordinator”* means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

*“Career exploration,”* also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

*“Career plan”* means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

*“Case management”* means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

*“Comprehensive service plan”* means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

*“Customized employment”* means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

*“Department”* means the Iowa department of human services.

*“Emergency”* means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

*“HCBS”* means home- and community-based services.

*“Individual employment”* means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

*“Individual placement and support”* means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

*“Integrated community employment”* means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

*“Integrated health home”* means the provision of services to enrolled members as described in subrule 78.53(1).

*“Interdisciplinary team”* means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

*“ISIS”* means the department’s individualized services information system.

*“Managed care organization”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

*“Member”* means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

*“Program”* means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

*“Supported employment”* means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

*“Supported self-employment”* includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

*“Sustained employment”* means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

**78.27(2) Member eligibility.** To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

- a. *Risk factors.* The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

*b. Need for assistance.* The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

*c. Income.* The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

*d. Needs assessment.* The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

*e. Plan for service.* The department has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

**78.27(3) Application for services.** The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

**78.27(4) Comprehensive service plan.** Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.



*a. Development.* A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

*b. Service goals and activities.* The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and

3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;

2. The number of hours per day of on-site staff supervision needed by the member; and

3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

*c. Rights restrictions.* Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

*d. Emergency plan.* The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

- (1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

- (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

- (3) Providers of applicable services shall provide for emergency backup staff.

*e. Plan approval.* Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)“e.”

**78.27(5) Requirements for services.** Home- and community-based habilitation services shall be provided in accordance with the following requirements:

- a.* The services shall be based on the member's needs as identified in the member's comprehensive service plan.

- b.* The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

- c.* The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

- d.* Service components that are the same or similar shall not be provided simultaneously.

- e.* Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

- f.* Reimbursement is not available for room and board.

- g.* Services shall be billed in whole units.

- h.* Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

**78.27(6) Case management.** Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

- a. Scope.* Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

- b. Exclusions.*

- (1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

- (2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

**78.27(7) Home-based habilitation.** “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

- a. Scope.* Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member

shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

*b. Exclusions.* Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

**78.27(8) Day habilitation.** "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

*a. Scope.* Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

- (1) Intellectual functioning;
- (2) Physical and emotional health and development;
- (3) Language and communication development;
- (4) Cognitive functioning;
- (5) Socialization and community integration;
- (6) Functional skill development;
- (7) Behavior management;
- (8) Responsibility and self-direction;
- (9) Daily living activities;
- (10) Self-advocacy skills; or
- (11) Mobility.

*b. Setting.* Day habilitation shall take place in community-based, nonresidential settings separate from the member's residence.

*c. Duration.* Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

*d. Exclusions.* Day habilitation payment shall not be made for the following:

- (1) Vocational or prevocational services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in day habilitation services.

**78.27(9) Prevocational service habilitation.** “Prevocational services” means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

*a. Scope.* Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member’s experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member’s local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member’s family, guardian or legal representative to introduce them to supported employment and explore the member’s employment goals and experiences,
2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

*b. Setting.* Prevocational services shall take place in community-based nonresidential settings.

*c. Concurrent services.* A member’s individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

*d. Exclusions.* Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

*e. Limitations.*

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9)"a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)"a"(1). This time limit can be extended as stated in paragraphs 78.27(9)"e"(1)"1" through "6." If the criteria in paragraphs 78.27(9)"e"(1)"1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

**78.27(10) Supported employment services.**

*a. Individual supported employment.* Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10) "a"(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

*b. Long-term job coaching.* Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)"b"(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
  2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
  3. Ongoing benefits education and support.
- (6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

*c. Small-group supported employment.* Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight

workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.

11. Transportation of the member during service hours.

- d. *Service requirements for all supported employment services.*

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).



(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

*e. Limitations.* Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,059.29 per month.

(3) Individual supported employment is limited to 240 units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

*f. Exclusions.* Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

**78.27(11) Adverse service actions.**

*a. Denial.* Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

*b. Reduction.* A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

*c. Termination.* A particular home- and community-based habilitation service may be terminated when the department determines that:

- (1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.
- (2) The service is not identified in the member's comprehensive service plan.
- (3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.
- (4) The member's service needs are not being met by the services provided.
- (5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.
- (6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.
- (7) Duplication of services provided during the same period has occurred.
- (8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.
- (9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

*d. Appeal rights.* The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

**78.27(12) County reimbursement.** Rescinded IAB 7/11/12, effective 7/1/12.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20]

**441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.**

**78.28(1)** Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

- a.* Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.
- b.* Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5) "*d.*"
- c.* Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5) "*l.*"
- d.* Rescinded IAB 5/11/05, effective 5/1/05.
- e.* Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5) "*f.*"
- f.* Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies

to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

- g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5) "a."
- h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2) "c")
- i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5) "m."
- j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5) "c."
- k. Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5) "e."
- l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5) "n."
- m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5) "g."
- n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5) "h."
- o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5) "i."
- p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5) "j."
- q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r. Customized wheelchairs, subject to the requirements of 78.10(2) "d."

**78.28(2)** Notwithstanding the provisions of 78.28(1) "a," under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a. Buprenorphine,
- b. Buprenorphine and naloxone combination,
- c. Methadone,
- d. Naltrexone, and
- e. Naloxone.

For the purpose of this subrule, "medication-assisted treatment" means the medically monitored use of certain substance use disorder medications in combination with treatment services.

**78.28(3)** Dental services. Dental services which require prior approval are as follows:

- a. The following periodontal services:
  - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4) "b."
  - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4) "d."
  - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4) "e."
  - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4) "f."
  - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4) "g."
- b. The following prosthetic services:
  - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "b."
  - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7) "d."

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“c.”

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“a.”

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“b.”

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“c.”

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“d”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“d”(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“d.”

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“g.”

**78.28(4)** Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

**78.28(5)** Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross reference 78.14(7)“d”(1))

*b.* A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7) “d”(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

**78.28(6)** Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

*a.* Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

*b.* All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

*c.* Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

**78.28(7)** Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

*a.* Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

*b.* Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

**78.28(8)** All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

*a.* Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

*b.* A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

**78.28(9)** Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or

behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

**78.28(10)** Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

*a.* Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

*b.* Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work

toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

**78.28(11)** Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) “b”)

**78.28(12)** High-technology radiology procedures.

*a.* Except as provided in paragraph 78.28(12) “b,” the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

*b.* Notwithstanding paragraph 78.28(12) “a,” prior authorization is not required when any of the following applies:

- (1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;
- (2) The member has Medicare coverage;
- (3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member’s receipt of such notice (see paragraph 78.28(12) “e”); or
- (4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

*c.* Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

*d.* Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department’s contractor for prior approval of high-technology radiology procedures.

*e.* Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member’s retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

**441—78.29(249A) Behavioral health services.** Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

**78.29(1) Limitations.**

- a. An assessment and a treatment plan are required.
- b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

**78.29(2) Exclusions.** Payment will not be approved for the following services:

- a. Services provided in a medical institution.
- b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

**78.29(3) Payment.**

- a. Payment shall be made only for time spent in face-to-face consultation with the member.
- b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

**441—78.30(249A) Birth centers.** Payment will be made for prenatal, delivery, and postnatal services.

**78.30(1) Risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
- b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

**78.30(2) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.31(249A) Hospital outpatient services.**

**78.31(1) Covered hospital outpatient services.** Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.



- e.* Follow-up or after-care specialty clinics.
- f.* Physical medicine and rehabilitation.
- g.* Alcoholism and substance abuse.
- h.* Eating disorders.
- i.* Cardiac rehabilitation.
- j.* Mental health.
- k.* Pain management.
- l.* Diabetic education.
- m.* Pulmonary rehabilitation.
- n.* Nutritional counseling for persons aged 20 and under.

**78.31(2) Requirements for all outpatient services.**

*a. Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

*b. Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

*c. Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

*d. Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

*e. Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

*f. Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

*g. Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

*h. Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**78.31(3) Application for certification.** Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

- a.* Documented need for the program including studies, needs assessments, and consultations with other health care professionals.
- b.* Goals and objectives of the program.
- c.* Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

**78.31(4) Requirements for specific types of service.**

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

- Referral form.
- Physician's orders.
- Laboratory reports.
- Electrocardiogram reports.
- History and physical examination.
- Angiogram report, if applicable.
- Operative report, if applicable.
- Preadmission interview.
- Exercise prescription.
- Rehabilitation plan, including participant's goals.
- Documentation for exercise sessions and progress notes.
- Nurse's progress reports.
- Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

*d. Mental health.*

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.



3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

*e. Pain management.*

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

*f.* Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

*g.* Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

*h.* Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

**78.31(5)** *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.32(249A) Area education agencies.** Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.33(249A) Case management services.** Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—78.34(249A) HCBS ill and handicapped waiver services.** Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek

employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.34(1) *Homemaker services.*** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

*a.* Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

*b.* Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

*c.* Meal preparation: planning and preparing balanced meals.

**78.34(2) *Home health services.*** Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

*a.* Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

*b.* In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

*c.* Skilled nursing care is not covered.

**78.34(3) *Adult day care services.*** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.34(4) *Nursing care services.*** Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

**78.34(5) *Respite care services.*** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

*a.* Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

*b.* Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

*c.* A unit of service is 15 minutes.

*d.* Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be

used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

*e.* The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

*f.* A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

*g.* Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

*h.* Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.34(6) *Counseling services.*** Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

**78.34(7) *Consumer-directed attendant care service.*** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
  - (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
  - (8) Colostomy care.
  - (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
  - (10) Postsurgical nursing care.
  - (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
  - (12) Preparing and monitoring response to therapeutic diets.
  - (13) Recording and reporting of changes in vital signs to the nurse or therapist.
- h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):
- (1) Any activity related to supervising a member. Only direct services are billable.
  - (2) Any activity that the member is able to perform.
  - (3) Costs of food.
  - (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
  - (5) Exercise that does not require skilled services.
  - (6) Parenting or child care for or on behalf of the member.
  - (7) Reminders and cueing.
  - (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
  - (9) Transportation costs.
  - (10) Wait times for any activity.

**78.34(8) Interim medical monitoring and treatment services.** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a. Need for service.* The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

*b. Service requirements.* Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

**78.34(9) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.



- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.34(10) *Personal emergency response or portable locator system.***

- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
  - (1) The required components of the system are:
    - 1. An in-home medical communications transceiver.
    - 2. A remote, portable activator.
    - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
    - 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
  - (2) The service shall be identified in the member's service plan.
  - (3) A unit of service is a one-time installation fee or one month of service.
  - (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.
- b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.
  - (1) The required components of the portable locator system are:
    - 1. A portable communications transceiver or transmitter to be worn or carried by the member.
    - 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
  - (2) The service shall be identified in the member's service plan.
  - (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
  - (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.34(11) *Home-delivered meals.*** Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

- a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of

the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

*b.* When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

*c.* A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

*d.* The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.34(12) *Nutritional counseling.*** Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

**78.34(13) *Consumer choices option.*** The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

*a. Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

*b. Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.

9. Transportation.
- (3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:
  1. Consumer-directed attendant care (unskilled).
  2. Home-delivered meals.
  3. Homemaker service.
  4. Basic individual respite care.
- (4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:
  1. Consumer-directed attendant care (unskilled).
  2. Day habilitation.
  3. Home and vehicle modification.
  4. Prevocational services.
  5. Basic individual respite care.
  6. Supported community living.
  7. Supported employment.
  8. Transportation.
- (5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:
  1. Consumer-directed attendant care (unskilled).
  2. Home and vehicle modification.
  3. Prevocational services.
  4. Basic individual respite care.
  5. Specialized medical equipment.
  6. Supported community living.
  7. Supported employment.
  8. Transportation.
- (6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:
  1. Consumer-directed attendant care (unskilled).
  2. Home and vehicle modification.
  3. Specialized medical equipment.
  4. Transportation.
- (7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13) "b"(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.
- (8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.
- (9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.
- (10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(8).
- (11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13) "b"(7) or the utilization adjustment factor in subparagraph 78.34(13) "b"(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included

in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member's need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

*c. Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

*d. Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

*e. Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)"d." At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed

community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
  2. Clothing not related to an assessed medical need.
  3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
  4. Costs associated with shipping items to the member.
  5. Experimental and non-FDA-approved medications, therapies, or treatments.
  6. Goods or services covered by other Medicaid programs.
  7. Home furnishings.
  8. Home repairs or home maintenance.
  9. Homeopathic treatments.
  10. Insurance premiums or copayments.
  11. Items purchased on installment payments.
  12. Motorized vehicles.
  13. Nutritional supplements.
  14. Personal entertainment items.
  15. Repairs and maintenance of motor vehicles.
  16. Room and board, including rent or mortgage payments.
  17. School tuition.
  18. Service animals.
  19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
  20. Sheltered workshop services.
  21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
  22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
  23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.
  24. Residential services provided to three or more members living in the same residential setting.
- (4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)"b"(11).

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)"d." The savings plan shall meet the requirements in paragraph 78.34(13)"f."

*f. Savings plan.* A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

- (1) The savings plan shall identify:
  1. The specific goods, services, supports or supplies to be purchased through the savings plan.
  2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

*g. Budget authority.* The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).
- (3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

*h. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.

- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

*i. Delegation of budget and employer authority.* The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)“g” and employer authority tasks identified in paragraph 78.34(13)“h.” Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member’s service plan.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.
- (4) The representative shall not be paid for this service.

*j. Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member’s representative:

- (1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member’s individual budget has addressed the member’s needs and the satisfaction of the member.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

- (1) Receive Medicaid funds in an electronic transfer.
- (2) Process and pay invoices for approved goods and services included in the individual budget.
- (3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
  1. Verifying that hourly wages comply with federal and state labor rules.
  2. Collecting and processing timecards.
  3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
  4. Computing and processing other withholdings, as applicable.
  5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
  6. Preparing and issuing employee payroll checks.
  7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
  8. Processing federal advance earned income tax credit for eligible employees.
  9. Refunding over-collected FICA, when appropriate.
  10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.
- (18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

*m. Responsibilities of the member and the employee.* A member participating in the CCO and the member's employee(s) are responsible for the following:

- (1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.
- (2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) Employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. Documentation shall comport with 441—subparagraph 79.3(2) "c"(3), "Service documentation."

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13) "m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately



describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

**78.34(14) General service standards.** All ill and handicapped waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

*c.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.35(249A) Occupational therapist services.** Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

**441—78.36(249A) Hospice services.**

**78.36(1) General characteristics.** A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

*a.* Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

*b. Noncovered services.*

- (1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.
- (2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.
- (3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.
- (4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

**78.36(2) *Categories of care.*** Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

- a.* Routine home care is care provided in the place of residence that is not continuous.
- b.* Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.
- c.* Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.
- d.* General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

**78.36(3) *Residence in a nursing facility.*** For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility,

the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

- a. The resident is terminally ill.
- b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

**78.36(4) Approval for hospice benefits.** Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. *Physician certification process.* The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. *Election procedures.* Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

**441—78.37(249A) HCBS elderly waiver services.** Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.37(1) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.37(2) Personal emergency response or portable locator system.**

*a.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of a system are:
  1. An in-home medical communications transceiver.
  2. A remote, portable activator.
  3. A central monitoring station with backup systems staffed by trained attendants at all times.
  4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

*b.* A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
  1. A portable communications transceiver or transmitter to be worn or carried by the member.
  2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.37(3) *Home health aide services.*** Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

**78.37(4) *Homemaker services.*** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

**78.37(5) *Nursing care services.*** Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

**78.37(6) *Respite care services.*** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

*h.* Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.37(7) *Chore services.*** Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7)“*a*,” as necessary to allow a member to remain in the member’s own home safely and independently. A unit of service is 15 minutes.

*a.* Chore services are limited to the following services:

- (1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
- (2) Minor repairs to walls, floors, stairs, railings and handles;
- (3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;
- (4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

*b.* Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

**78.37(8) *Home-delivered meals.*** Home-delivered meals are meals prepared elsewhere and delivered to a member at the member’s residence.

*a.* Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

*b.* When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

*c.* A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member’s service plan.

*d.* The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.37(9) *Home and vehicle modification.*** Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

*b.* Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.37(10) *Mental health outreach.*** Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

**78.37(11) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**78.37(12) *Nutritional counseling.*** Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

**78.37(13) *Assistive devices.*** Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.37(14) Senior companion.** Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

**78.37(15) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15) “f” and the skilled activities listed in paragraph 78.37(15) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:



(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.37(16) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.37(17) Case management services.** Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

*a.* Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

*b.* Case management shall not include the provision of direct services by the case managers.

*c.* Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

**78.37(18) Assisted living service.** The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

*a.* A unit of service is one day.

*b.* A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

**78.37(19) General service standards.** All elderly waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

*c.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
- (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.
- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20]

**441—78.38(249A) HCBS AIDS/HIV waiver services.** Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.38(1) Counseling services.** Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

**78.38(2) Home health aide services.** Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.

- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

**78.38(3) *Homemaker services.*** Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

- c. Meal preparation: planning and preparing balanced meals.

**78.38(4) *Nursing care services.*** Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

**78.38(5) *Respite care services.*** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

- c. A unit of service is 15 minutes.

- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

**78.38(6) *Home-delivered meals.*** Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

- a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

**78.38(7) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.38(8) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.38(9) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.38(10) General service standards.** All AIDS/HIV waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

*c.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.39(249A) Federally qualified health centers.** Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

**78.39(1) Utilization review.** Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.39(2) Risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

**78.39(3) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.40(249A) Advanced registered nurse practitioners.** Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

**78.40(1) Direct payment.** Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

**78.40(2) Location of service.** Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

**78.40(3) Utilization review.** Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

**78.40(4) Vaccines.** In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

**78.40(5) Prenatal risk assessment.** Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.



b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.41(249A) HCBS intellectual disability waiver services.** Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.41(1) Supported community living services.** Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human

body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

**78.41(2) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.
- i. Payment for respite services shall not exceed \$7,334.62 per the member's waiver year.

**78.41(3)** *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of the system are:
  - 1. An in-home medical communications transceiver.
  - 2. A remote, portable activator.
  - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
  - 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
  - 1. A portable communications transceiver or transmitter to be worn or carried by the member.
  - 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.41(4)** *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.41(5) *Nursing services.*** Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

**78.41(6) *Home health aide services.*** Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

**78.41(7) Supported employment services.** Supported employment services are service activities provided pursuant to subrule 78.27(10).

**78.41(8) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8) “f” and the skilled activities listed in paragraph 78.41(8) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

**78.41(9)** *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a.* Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

*b.* Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

*c.* Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

*d.* Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

*e.* A unit of service is 15 minutes.

**78.41(10) Residential-based supported community living services.** Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

**78.41(11) Transportation.** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

**78.41(12) Adult day care services.** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.41(13) Prevocational services.** Prevocational services are service activities provided pursuant to subrule 78.27(9).

**78.41(14) Day habilitation services.**



*a. Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

*b. Family training option.* Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

*c. Unit of service.* Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

*d. Exclusions.*

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

**78.41(15) Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.41(16) General service standards.** All intellectual disability waiver services must be provided in accordance with the following standards:

*a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

*b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

*c.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

*d.* Services must be billed in whole units.

*e.* For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.42(249A) Pharmacies administering influenza vaccine to children.** Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.43(249A) HCBS brain injury waiver services.** Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.43(1) Case management services.** Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

*a.* Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

*b.* The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

*c.* The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

*d.* Members who are eligible for targeted case management are not eligible for case management as a waiver service.

**78.43(2) Supported community living services.** Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

*a.* The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

**78.43(3) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

**78.43(4) Supported employment services.** Supported employment services are service activities provided pursuant to subrule 78.27(10).

**78.43(5) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically

included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.  
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

**78.43(6) *Personal emergency response or portable locator system.***

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.43(7) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

**78.43(8) *Specialized medical equipment.***

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.43(9) *Adult day care services.*** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25

to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

**78.43(10) *Family counseling and training services.*** Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

**78.43(11) *Prevocational services.*** Prevocational services are service activities provided pursuant to subrule 78.27(9).

**78.43(12) *Behavioral programming.*** Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

**78.43(13) *Consumer-directed attendant care service.*** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)“f” and the skilled activities listed in paragraph 78.43(13)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.



(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.43(14) *Interim medical monitoring and treatment services.*** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

*a. Need for service.* The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

*b. Service requirements.* Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

**78.43(15) *Consumer choices option.*** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.43(16) *General service standards.*** All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20]

**441—78.44(249A) Lead inspection services.** Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.45(249A) Assertive community treatment.** Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

**78.45(1) Applicability.** ACT services may be provided only to a member who meets all of the following criteria:

*a.* The member is at least 17 years old.

*b.* The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

*c.* The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

*d.* The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

- (1) Is medically stable;
- (2) Does not require a level of care that includes more intensive medical monitoring;
- (3) Presents a low risk to self, others, or property, with treatment and support; and
- (4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

**78.45(2) Services.** The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

- (1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and
- (2) Ensuring that the member keeps appointments.

*f. Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.
2. Assisting the member in gaining access to necessary medical, social, educational, and other services.
3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.
2. Make referrals to services and related activities to assist the member with the assessed needs.
3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

*g. Crisis response.* Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

*h. Work-related services.* Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
- (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
- (3) Providing supports to maintain employment, such as crisis intervention related to employment.
- (4) Teaching communication, problem solving, and safety skills.
- (5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—78.46(249A) Physical disability waiver service.** Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.46(1) Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

*a. Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

*b. Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

*c. Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

*d. Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

*e. Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

*f. Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.

- (2) Bathing, shampooing, hygiene, and grooming.

- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

*g. Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

*h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

**78.46(2) Home and vehicle modification.** Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

*a.* Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

*b.* Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

*c.* A unit of service is the completion of needed modifications or adaptations.

*d.* All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

*e.* Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

*f.* All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

*g.* Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

*h.* Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.



**78.46(3) *Personal emergency response or portable locator system.***

*a.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

*b.* A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

**78.46(4) *Specialized medical equipment.***

*a.* Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

*b.* Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

*c.* Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

*d.* The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

*e.* Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.46(5) *Transportation.*** Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

**78.46(6) *Consumer choices option.*** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

**78.46(7) General service standards.** All physical disability waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
  - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
  - (2) The need for the restriction.
  - (3) The less intrusive methods of meeting the need that have been tried but did not work.
  - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
  - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
  - (6) The informed consent of the member.
  - (7) An assurance that the interventions and supports will cause no harm to the member.
  - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
  - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
  - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
  - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
  - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

**441—78.47(249A) Pharmaceutical case management services.** Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

**78.47(1) Medicaid recipient eligibility.** Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

**78.47(2) Provider eligibility.** Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

- a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

**78.47(3) Services.** Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;

3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. *New problem assessments.* These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. *Problem follow-up assessments.* These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. *Preventive follow-up assessments.* These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

**441—78.48(249A) Public health agencies.** Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

**441—78.49(249A) Infant and toddler program services.** Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

**78.49(1) Covered services.** Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

**78.49(2) Case management services.** Payment shall also be approved for infant and toddler case management services subject to the following requirements:

*a. Definition.* “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

*b. Choice of provider.* Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

*c. Assessment.* The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child’s history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

*d. Plan of care.* The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs.

These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

*e. Other service components.* Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

*f. Documentation of case management.* For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

(3) The agency chosen by the family to provide the case management services;

(4) The nature, content, and units of case management services received;

(5) Whether the goals specified in the care plan have been achieved;

(6) Whether the family has declined services in the care plan;

(7) Time lines for providing services and reassessment; and

(8) The need for and occurrences of coordination with case managers of other programs.

**78.49(3) *Child's eligibility.*** Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

**78.49(4) *Delivery of services.*** Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

**78.49(5) *Remission of nonfederal share of costs.*** Payment for services shall be made only when the following conditions are met:

- a. Rescinded IAB 5/10/06, effective 7/1/06.
- b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

**441—78.50(249A) Local education agency services.** Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

**78.50(1) *Covered services.*** Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

**78.50(2) *Coordination services.*** Rescinded IAB 12/3/08, effective 2/1/09.

**78.50(3) *Delivery of services.*** Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

**78.50(4) *Remission of nonfederal share of costs.*** Payment for services shall be made only when the following conditions are met:

- a. Rescinded IAB 5/10/06, effective 7/1/06.
- b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

**441—78.51(249A) Indian health service 638 facility services.** Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

This rule is intended to implement Iowa Code section 249A.4.

**441—78.52(249A) HCBS children's mental health waiver services.** Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established

in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.52(1) General service standards.** All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

**78.52(2) Environmental modifications and adaptive devices.**

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

**78.52(3) Family and community support services.** Family and community support services shall support the member and the member's family by the development and implementation of strategies and

interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

**78.52(4) *In-home family therapy.*** In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.



a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

**78.52(5) Respite care services.** Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—78.53(249A) Health home services.** Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

**78.53(1) Covered services.** Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

- (2) Improving disease control; and
- (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
  - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
  - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
- e. Member and family support (including authorized representatives). This support may include:
  - (1) Communicating with and advocating for the member or family for the assessment of care decisions;
  - (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
  - (3) Increasing health literacy and self-management skills; and
  - (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.
- f. Referral to community and social support services available in the community.

**78.53(2) *Members eligible for health home services.***

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

- (1) Has at least two chronic conditions;
- (2) Has one chronic condition and is at risk of having a second chronic condition;
- (3) Has a serious mental illness; or
- (4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

- (1) A mental health disorder.
- (2) A substance use disorder.
- (3) Asthma.
- (4) Diabetes.
- (5) Heart disease.
- (6) Being overweight, as evidenced by:
  - 1. Having a body mass index (BMI) over 25 for an adult, or
  - 2. Weighing over the 85th percentile for the pediatric population.
- (7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

- (1) A psychotic disorder;
- (2) Schizophrenia;
- (3) Schizoaffective disorder;
- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

**78.53(3) Selection of health home services provider.** As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

**441—78.54(249A) Speech-language pathology services.** Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—78.55(249A) Services rendered via telehealth.** An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

**441—78.56(249A) Community-based neurobehavioral rehabilitation services.** Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

**78.56(1) Definitions.**

*"Assessment"* means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

*"Brain injury"* means a diagnosis in accordance with rule 441—83.81(249A).

*"Health care"* means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

*"Intermittent community-based neurobehavioral rehabilitation services"* are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

*"Member"* means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

*"Neurobehavioral rehabilitation"* refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

*"Program"* means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

“*Standardized assessment*” means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member’s individual needs.

**78.56(2) Member eligibility.** To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

*a. Brain injury diagnosis.* To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

*b. Risk factors.* The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

*c. Need for assistance.* The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

*d. Needs assessment.* The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member’s managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

*e. Standards for assessment.* Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member’s ability to self-manage the member’s symptoms.

(3) The member’s rehabilitation and medical care history to include medication history and status.

(4) The member’s employment history and the member’s barriers to employment.

(5) The member’s dietary and nutritional needs.

(6) The member’s community accessibility and safety.

(7) The member’s access to transportation.

(8) The member’s history of substance abuse.

(9) The member’s vulnerability to exploitation and history of risk of exploitation.

(10) The member’s history and status of relationships, natural supports and socialization.

*f. Emergency admission.* In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

**78.56(3) Covered services.**

*a. Service setting.*

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member’s own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

*b.* Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

- (1) Prescriptive programming to maintain and advance progress made in rehabilitation;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Assistance in obtaining preventative, appropriate and timely medical and dental care;
- (4) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;
- (6) Behavioral and cognitive programming and supports;
- (7) Medication management and consultation with pharmacy;
- (8) Health and wellness management including dietary and nutritional programming;
- (9) Progressive physical strengthening, fitness and retraining;
- (10) Assistance with obtaining and use of assistive technology;
- (11) Sobriety support development;
- (12) Assistance with the self-identification of antecedent triggers;
- (13) Assistance with preparation for transition to less intensive services including accessing the community;
- (14) Flexibility in programming to meet individual needs;
- (15) Assistance with re-learning coping and compensatory strategies;
- (16) Support and assistance in seeking substance abuse and co-occurring disorders services;
- (17) Support and assistance with obtaining legal consultation and services;
- (18) Assistance with community accessibility and safety;
- (19) Assistance with re-learning household maintenance;
- (20) Assistance with recreational and leisure skill development;
- (21) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (22) Opportunities to learn about brain injury and individual needs following brain injury;
- (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (24) Assistance with pursuit of education and employment goals;
- (25) Protective oversight in the residential setting and community;
- (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
- (27) Transitional support and training;
- (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
- (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

*c.* Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;
- (8) Assistance with re-learning coping and compensatory strategies;

(9) Assistance with the development and application of self-advocacy skills to navigate the service system;

(10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;

(12) Transitional support and training;

(13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

*d.* Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

*e.* Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

(1) The IME medical services unit will approve the provider's treatment plan if:

1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);

2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;

3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and

5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

*f.* Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

*g.* Quality review. The IME medical services unit may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.54(249A).

**78.56(4) Medical necessity.** Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

*a.* Consistent with the diagnosis and treatment of the member's condition;

*b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

*c.* The least costly type of service that can reasonably meet the medical needs of the member; and

*d.* In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

**78.56(5) Documentation standards.** Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

**441—78.57(249A) Child care medical services.** Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

**78.57(1)** Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

**78.57(2)** Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

**78.57(3)** Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

**78.57(4)** Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

**78.57(5)** "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

**78.57(6) Requirements.**

*a.* Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

*b.* Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

*c.* Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A

treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
  - (2) Type of service to be rendered and the treatment modalities being used.
  - (3) Frequency of the services.
  - (4) Assistance devices to be used.
  - (5) Date on which services were initiated.
  - (6) Progress of member in response to treatment.
  - (7) Medical supplies to be furnished.
  - (8) Member's medical condition as reflected by the following information, if applicable:
    1. Dates of prior hospitalization.
    2. Dates of prior surgery.
    3. Date last seen by a primary care provider.
    4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
    5. Prognosis.
    6. Functional limitations.
    7. Vital signs reading.
    8. Date of last episode of acute recurrence of illness or symptoms.
    9. Medications.
    - (9) Discipline of the person providing the service.
    - (10) Certification period.
    - (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
    - (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.
  - 78.57(7)** Nursing, personal care, and psychosocial services do not include:
    - a. Services provided to members aged 21 and older.
    - b. Services that require prior authorizations that are provided without regard to the prior authorization process.
    - c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
    - d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
    - e. Transportation services.
    - f. Services provided to a member while the member is in institutional care.
- This rule is intended to implement Iowa Code chapter 249A.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

#### **441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.**

**78.58(1) Payment.** Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

#### **78.58(2) Definitions.**

*"Coinsurance"* means a percentage of costs of a covered health care service that has to be paid.

*"Copayment"* means a fixed amount a member pays for a covered health care service.

*"Deductible"* means the amount paid for covered health care services before the insurance plan will effect payment.

*"Medicare cost sharing"* means the Medicare member's responsibility for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

*"Qualified Medicare beneficiary"* or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the



individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—78.59(249A) Health insurance premium payment (HIPP) provider services.**

**78.59(1) Reimbursement.** A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

**78.59(2) Definitions.**

*"Coinsurance"* means a percentage of costs of a covered health care service that has to be paid.

*"Copayment"* means a fixed amount a member pays for a covered health care service.

*"Cost sharing"* means the member's health insurance in-network responsibility for a covered service. "Cost sharing" includes coinsurance, copayments, and deductibles.

*"Deductible"* means the amount paid for covered health care services before the insurance plan will effect payment.

*"Eligible member"* means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

*"Health insurance premium payment (HIPP) program"* or *"HIPP program"* has the same meaning as provided in rule 441—75.21(249A).

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—78.60(249A) Crisis response services.** Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

**441—78.61(249A) Subacute mental health services.** Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

[Filed 3/11/70; amended 3/20/74]

[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]

[Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]

[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]

[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]

[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]

[Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]

[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]

[Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]

[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]

[Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]

[Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]

[Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]

[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]

- [Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
- [Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
- [Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
- [Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]
- [Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]
- [Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]
- [Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]
- [Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]
- [Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
- [Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]
- [Filed 1/4/79, Notice 11/29/78—published 1/24/79, effective 3/1/79]
- [Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]
- [Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 6/1/79]
- [Filed 7/3/79, Notice 4/18/79—published 7/25/79, effective 8/29/79]
- [Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
- [Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79]
- [Filed emergency 9/6/79 after Notice 7/11/79—published 10/3/79, effective 10/1/79]
- [Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
- [Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
- [Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
- [Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
- [Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
- [Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
- [Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
- [Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
- [Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
- [Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
- [Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
- [Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
- [Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
- [Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
- [Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]
- [Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
- [Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
- [Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
- [Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
- [Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
- [Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
- [Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
- [Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
- [Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notices 3/30/83, 4/13/83—published 6/8/83, effective 8/1/83]<sup>17 10</sup>
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 7/29/83—published 8/17/83, effective 8/1/83]<sup>17 10</sup>
- [Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]

- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84]<sup>1 7 10</sup>
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
- [Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
- [Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
- [Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
- [Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
- [Filed emergency 8/23/85—published 9/11/85, effective 9/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 10/18/85 after Notice 9/11/85—published 11/6/85, effective 11/1/85]
- [Filed 11/15/85, Notice 9/25/85—published 12/4/85, effective 2/1/86]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/1/86, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
- [Filed emergency 12/22/86—published 1/14/87, effective 2/1/87]
- [Filed 12/22/86, Notice 11/5/86—published 1/14/87, effective 3/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notices 12/17/86, 12/31/86, 1/14/87—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed 5/29/87, Notices 4/8/87, 4/22/87—published 6/17/87, effective 8/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 6/19/87, Notice 5/6/87—published 7/15/87, effective 9/1/87]
- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 8/28/87, Notices 6/17/87, 7/15/87—published 9/23/87, effective 11/1/87]
- [Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]<sup>2</sup>
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
- [Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
- [Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]

- [Filed 10/11/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
- [Filed 11/16/89, Notice 8/23/89—published 12/13/89, effective 2/1/90]
- [Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90]<sup>3</sup>
- [Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
- [Filed 3/16/90, Notices 11/15/89, 1/24/90, 2/7/90—published 4/4/90, effective 6/1/90]
- [Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notices 5/16/90, 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
- [Filed 9/28/90, Notices 7/11/90, 7/25/90, 8/8/90—published 10/17/90, effective 12/1/90]
- [Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed 11/16/90, Notices 9/19/90, 10/3/90—published 12/12/90, effective 2/1/91]
- [Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]<sup>4</sup>
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notice 3/20/91—published 7/10/91, effective 9/1/91]
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]<sup>5</sup>
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
- [Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]
- [Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92]<sup>1 7 10</sup>
- [Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]
- [Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]
- [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 9/11/92, Notices 7/8/92, 8/5/92—published 9/30/92, effective 12/1/92]
- [Filed 9/11/92, Notice 8/5/92—published 9/30/92, effective 1/1/93]
- [Filed 10/15/92, Notices 8/19/92, 9/2/92—published 11/11/92, effective 1/1/93]
- [Filed emergency 11/10/92—published 12/9/92, effective 11/10/92]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
- [Filed 1/14/93, Notices 10/28/92, 11/25/92—published 2/3/93, effective 4/1/93]
- [Filed emergency 4/15/93 after Notice 3/3/93—published 5/12/93, effective 5/1/93]
- [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
- [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
- [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
- [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
- [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
- [Filed emergency 7/14/93—published 8/4/93, effective 8/1/93]
- [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
- [Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]

[Filed 9/17/93, Notice 8/4/93—published 10/13/93, effective 12/1/93]  
[Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]  
[Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]  
[Filed emergency 12/16/93 after Notice 10/13/93—published 1/5/94, effective 1/1/94]  
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]  
[Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]  
[Filed emergency 2/10/94 after Notice 12/22/93—published 3/2/94, effective 3/1/94]  
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]  
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]  
[Filed 8/12/94, Notice 6/22/94—published 8/31/94, effective 11/1/94]  
[Filed 9/15/94, Notices 7/6/94, 8/3/94—published 10/12/94, effective 12/1/94]  
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]  
[Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/5/95]  
[Filed 5/11/95, Notices 3/29/95—published 6/7/95, effective 8/1/95]  
[Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]  
[Filed 6/14/95, Notice 5/10/95—published 7/5/95, effective 9/1/95]  
[Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]  
[Filed 11/16/95, Notices 8/2/95, 9/27/95<sup>6</sup>—published 12/6/95, effective 2/1/96]  
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]  
[Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]  
[Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]  
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]  
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]  
[Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]  
[Filed 1/15/97, Notice 12/4/96—published 2/12/97, effective 4/1/97]  
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]  
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]  
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]  
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]  
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]  
[Filed 7/9/97, Notice 5/21/97—published 7/30/97, effective 10/1/97]  
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]  
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]  
[Filed 1/14/98, Notice 11/19/97—published 2/11/98, effective 4/1/98]  
[Filed 4/8/98, Notices 2/11/98, 2/25/98—published 5/6/98, effective 7/1/98]  
[Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]  
[Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]  
[Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]  
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]  
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]  
[Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]  
[Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 3/1/99]  
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]  
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]  
[Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 6/1/99]  
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]  
[Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]  
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]  
[Filed 10/13/99, Notice 6/30/99—published 11/3/99, effective 1/1/00]  
[Filed 4/12/00, Notice 2/23/00—published 5/3/00, effective 7/1/00]  
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]  
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]

[Filed 6/8/00, Notices 1/26/00, 4/19/00—published 6/28/00, effective 9/1/00]  
 [Filed 8/9/00, Notices 6/14/00, 6/28/00—published 9/6/00, effective 11/1/00]  
 [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]  
     [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]  
     [Filed 10/11/00, Notice 4/19/00—published 11/1/00, effective 1/1/01]  
 [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]  
     [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]  
     [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]  
     [Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 7/4/01]  
     [Filed 5/9/01, Notices 1/24/01, 3/7/01—published 5/30/01, effective 8/1/01]  
 [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]  
     [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>1 7 10</sup>  
     [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]  
     [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]  
     [Filed 11/14/01, Notices 9/19/01, 10/3/01—published 12/12/01, effective 2/1/02]  
 [Filed emergency 12/12/01 after Notice 10/17/01—published 1/9/02, effective 12/12/01]  
     [Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]  
     [Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]<sup>1 7 10</sup>  
 [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]<sup>1 7 10</sup>  
     [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]<sup>8</sup>  
     [Filed emergency 2/14/02—published 3/6/02, effective 3/1/02]  
     [Filed 3/13/02, Notice 1/9/02—published 4/3/02, effective 6/1/02]  
     [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]  
     [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]  
     [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]  
     [Filed 4/10/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]  
     [Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]  
     [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]  
     [Filed emergency 8/15/02—published 9/4/02, effective 9/1/02]  
     [Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]  
     [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]  
     [Filed emergency 11/18/02—published 12/11/02, effective 12/15/02]<sup>9</sup>  
     [Filed 11/18/02, Notice 9/4/02—published 12/11/02, effective 2/1/03]  
 [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]  
     [Filed 12/12/02, Notice 10/30/02—published 1/8/03, effective 3/1/03]  
     [Filed emergency 1/9/03—published 2/5/03, effective 2/1/03]<sup>1 7 10</sup>  
     [Filed 2/13/03, Notice 11/27/02—published 3/5/03, effective 5/1/03]  
     [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]  
     [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]<sup>1 7 10</sup>  
     [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]<sup>1 7 10</sup>  
     [Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]  
     [Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]  
     [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]  
 [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]  
     [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]<sup>1 7 10</sup>  
     [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]  
     [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]  
     [Filed 7/15/05, Notice 5/25/05—published 8/3/05, effective 10/1/05]  
     [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]  
     [Filed emergency 10/21/05—published 11/9/05, effective 11/1/05]  
 [Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]<sup>1 7 10</sup>  
     [Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]

[Filed 1/12/06, Notice 11/9/05—published 2/1/06, effective 3/8/06]  
 [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]  
 [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]  
 [Filed 5/12/06, Notice 3/15/06—published 6/7/06, effective 8/1/06]  
 [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]  
 [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]  
 [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]  
 [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]  
 [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]  
 [Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]  
 [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]  
 [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]  
 [Filed emergency 3/14/07 after Notice 1/17/07—published 4/11/07, effective 4/1/07]  
 [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]  
 [Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]  
 [Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]  
 [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]  
 [Filed without Notice 7/20/07—published 8/15/07, effective 10/1/07]  
 [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]  
 [Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]  
 [Filed emergency 1/9/08 after Notice 10/10/07—published 1/30/08, effective 2/1/08]  
 [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]  
 [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 5/15/08]  
 [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]  
 [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]  
 [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]  
 [Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]  
 [Filed emergency 8/18/08—published 9/10/08, effective 9/1/08]  
 [Filed emergency 8/18/08 after Notice 7/2/08—published 9/10/08, effective 10/1/08]  
 [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]  
 [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]  
 [Filed 10/14/08, Notice 8/13/08—published 11/5/08, effective 1/1/09]  
 [Filed emergency 11/12/08 after Notice 9/10/08—published 12/3/08, effective 12/1/08]  
 [Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]  
 [Filed 12/11/08, Notice 9/10/08—published 1/14/09, effective 2/18/09]  
 [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]  
 [Filed ARC 7548B (Notice ARC 7369B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]  
 [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]<sup>11</sup>  
 [Filed Emergency After Notice ARC 8008B (Notice ARC 7771B, IAB 5/20/09), IAB 7/29/09, effective 8/1/09]  
 [Filed ARC 8097B (Notice ARC 7816B, IAB 6/3/09), IAB 9/9/09, effective 11/1/09]  
 [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]  
 [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]  
 [Filed ARC 8504B (Notice ARC 8247B, IAB 10/21/09), IAB 2/10/10, effective 3/22/10]  
 [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]  
 [Filed Emergency After Notice ARC 8714B (Notice ARC 8538B, IAB 2/24/10), IAB 5/5/10, effective 5/1/10]  
 [Filed ARC 8993B (Notice ARC 8722B, IAB 5/5/10), IAB 8/11/10, effective 10/1/10]  
 [Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]  
 [Filed ARC 9045B (Notice ARC 8832B, IAB 6/2/10), IAB 9/8/10, effective 11/1/10]

[Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]  
[Filed ARC 9175B (Notice ARC 8975B, IAB 7/28/10), IAB 11/3/10, effective 1/1/11]  
[Filed Emergency ARC 9256B, IAB 12/1/10, effective 1/1/11]  
[Filed Emergency ARC 9311B, IAB 12/29/10, effective 1/1/11]  
[Filed ARC 9315B (Notice ARC 9111B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]  
[Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]  
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]<sup>12</sup>  
[Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11,  
effective 4/1/11]  
[Editorial change: IAC Supplement 4/20/11]  
[Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]  
[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11),  
IAB 6/29/11, effective 9/1/11]  
[Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective  
8/1/11]  
[Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]  
[Filed Emergency ARC 9699B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9702B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9834B, IAB 11/2/11, effective 11/1/11]  
[Filed ARC 9882B (Notice ARC 9700B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9883B (Notice ARC 9703B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9981B (Notice ARC 9835B, IAB 11/2/11), IAB 2/8/12, effective 3/14/12]  
[Filed ARC 0065C (Notice ARC 9940B, IAB 12/28/11), IAB 4/4/12, effective 6/1/12]  
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective  
7/1/12]  
[Filed ARC 0305C (Notice ARC 0144C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]  
[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]  
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]  
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]  
[Filed ARC 0631C (Notice ARC 0497C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]  
[Filed ARC 0632C (Notice ARC 0496C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]  
[Filed ARC 0707C (Notice ARC 0567C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0709C (Notice ARC 0589C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]  
[Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]  
[Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC  
0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]  
[Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]  
[Filed Emergency ARC 0844C, IAB 7/24/13, effective 7/1/13]  
[Filed Emergency ARC 0846C, IAB 7/24/13, effective 7/1/13]  
[Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]  
[Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]  
[Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13,  
effective 10/1/13]  
[Filed ARC 1052C (Notice ARC 0845C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]



[Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1054C (Notice ARC 0843C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]  
 [Filed ARC 1151C (Notice ARC 0920C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]  
 [Filed ARC 1264C (Notice ARC 1161C, IAB 10/30/13), IAB 1/8/14, effective 3/1/14]  
 [Filed ARC 1297C (Notice ARC 1185C, IAB 11/13/13), IAB 2/5/14, effective 4/1/14]  
 [Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]  
 [Filed ARC 1696C (Notice ARC 1620C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]  
 [Filed ARC 1850C (Notice ARC 1729C, IAB 11/12/14), IAB 2/4/15, effective 4/1/15]  
 [Filed ARC 1976C (Notice ARC 1901C, IAB 3/4/15), IAB 4/29/15, effective 7/1/15]  
 [Filed Emergency After Notice ARC 2050C (Notice ARC 1982C, IAB 4/29/15), IAB 7/8/15, effective 7/1/15]  
 [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]  
 [Filed ARC 2166C (Notice ARC 2096C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]  
 [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]  
 [Filed ARC 2340C (Notice ARC 2115C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]  
 [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]  
 [Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]  
 [Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]  
 [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]  
 [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]  
 [Filed ARC 3005C (Notice ARC 2897C, IAB 1/18/17), IAB 3/29/17, effective 5/3/17]  
 [Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]  
 [Filed Emergency ARC 3481C, IAB 12/6/17, effective 12/1/17]  
 [Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]  
 [Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3552C (Notice ARC 3374C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3553C (Notice ARC 3419C, IAB 10/25/17), IAB 1/3/18, effective 2/7/18]  
 [Filed ARC 3790C (Notice ARC 3476C, IAB 12/6/17; Amended Notice ARC 3602C, IAB 1/31/18), IAB 5/9/18, effective 6/13/18]  
 [Filed ARC 3874C (Notice ARC 3784C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]  
 [Filed ARC 4430C (Notice ARC 4288C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]<sup>13</sup>  
 [Filed ARC 4575C (Notice ARC 4444C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]  
 [Filed ARC 4792C (Notice ARC 4628C, IAB 8/28/19), IAB 12/4/19, effective 1/8/20]  
 [Filed ARC 4897C (Notice ARC 4739C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]  
 [Filed ARC 4899C (Notice ARC 4763C, IAB 11/20/19), IAB 2/12/20, effective 3/18/20]<sup>14</sup>

<sup>1</sup> Two ARCs

<sup>2</sup> Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

<sup>3</sup> Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

<sup>4</sup> Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

<sup>5</sup> Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

<sup>6</sup> Two ARCs

<sup>7</sup> Two ARCs

<sup>8</sup> At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

- <sup>9</sup> Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- <sup>10</sup> Two or more ARCs
- <sup>11</sup> July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- <sup>12</sup> May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.
- <sup>13</sup> July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- <sup>14</sup> March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 79  
OTHER POLICIES RELATING TO PROVIDERS OF  
MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

**441—79.1(249A) Principles governing reimbursement of providers of medical and health services.** The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

**79.1(1) Types of reimbursement.**

*a. Prospective cost-related.* Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

*b. Retrospective cost-related.* Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

*c. Fee schedules.* Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: [dhs.iowa.gov/ime/providers/csrp/fee-schedule](https://dhs.iowa.gov/ime/providers/csrp/fee-schedule).

*d. Fee for service with cost settlement.* Rescinded IAB 10/10/18, effective 12/1/18.

*e. Retrospectively limited prospective rates.* Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e"(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

*f. Contractual rate.* Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

*g. Retrospectively adjusted prospective rates.* Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

*h. Indian health facilities.*

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

**79.1(2)** *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<p>1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below.</p> <p>2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.</p> <p>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.</p>
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	<p>For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Fee schedule</p> <p>For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)</p>	<p>Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or \$1.47 per 15-minute unit, \$23.47 per half day, \$46.72 per full day, or \$70.06 per extended day if no Veterans Administration contract.</p> <p>Effective 7/1/17, for intellectual disability waiver: The provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute or half-day rate. If no 6/30/16 rate, \$1.96 per 15-minute unit or \$31.27 per half day.</p> <p>For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).</p>
2. Emergency response system: Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%.  For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$87.99 per visit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.



<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum.  For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum.  For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, \$3.58 per 15-minute unit, not to exceed \$83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/18.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.51 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$16.07 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule. See 79.1(24) "d"	Fee schedule in effect 7/1/18.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)“r.”	Effective 7/1/18: Medicare LUPA rates in effect on 6/30/18 plus a 3% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)“h”	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare).
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.



<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)“d”	Fee schedule in effect 7/1/17. See 79.1(7)“d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)“c”	Rate provided by 79.1(7)“c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

**79.1(3) Ambulatory surgical centers.**

*a.* Payment is made for facility services on a fee schedule determined by the department and published on the department’s website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

*b.* Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

**79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers.** Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

**79.1(5) Reimbursement for hospitals.**

*a. Definitions.*

“Adolescent” shall mean a Medicaid patient 17 years or younger.

“Adult” shall mean a Medicaid patient 18 years or older.

“Average daily rate” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

*“Base year cost report”* means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5) “x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

*“Blended base amount”* shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

*“Blended capital costs”* shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

*“Capital costs”* shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

*“Case-mix adjusted”* shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

*“Case-mix index”* shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

*“Children’s hospitals”* shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

*"Cost outlier"* shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

*"Critical access hospital"* or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

*"Diagnosis-related group (DRG)"* shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

*"Direct medical education costs"* shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

*"Direct medical education rate"* shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

*"Disproportionate share payment"* shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

*"Disproportionate share percentage"* shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) "y"(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

*"Disproportionate share rate"* shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

*"DRG weight"* shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

*"Final payment rate"* shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's

reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

*“Full DRG transfer”* shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

*“GME/DSH fund apportionment claim set”* means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

*“GME/DSH fund implementation year”* means 2009.

*“Graduate medical education and disproportionate share fund”* or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

*“Indirect medical education rate”* shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

*“Inlier”* shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

*“Long stay outlier”* shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

*“Low-income utilization rate”* shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

*“Medicaid claim set”* means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

*“Medicaid inpatient utilization rate”* shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

*“Neonatal intensive care unit”* shall mean a designated level II or level III neonatal unit.

*“Net discharges”* shall mean total discharges minus transfers and short stay outliers.

*“Quality improvement organization”* or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

*“Rate table listing”* shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

*“Rebasing”* shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

*“Rebasing implementation year”* means 2008 and every three years thereafter.

*“Recalibration”* shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

*“Short stay day outlier”* shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*“f.”*

*b. Determination of final payment rate amount.* The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*“r.”* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*“r.”* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

*c. Calculation of Iowa-specific weights and case-mix index.* From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

- (2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

- (3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

- d. Calculation of blended base amount.* The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

- (1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

- (2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

- (3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

- e. Add-ons to the base amount.*

- (1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

*f. Outlier payment policy.* Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

*g. Billing for patient transfers and readmissions.*



(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

*h. Covered DRGs.* Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5) "r," and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5) "r," which are paid per diem, as specified in paragraph 79.1(5) "i."

*i. Payment for certified physical rehabilitation hospitals and units and psychiatric units.* Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5) "r" and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5) "r" is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5) "a." No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5) "j."

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

*j. Services covered by DRG payments.* Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

*k. Inflation factors, rebasing, and recalibration.*

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5) "y"(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

*l. Eligibility and payment.* When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

*m. Payment to out-of-state hospitals.* Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

*n. Preadmission, preauthorization, or inappropriate services.* Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

*o. Hospital billing.* Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

*p. Determination of inpatient admission.* A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

*q. Inpatient admission after outpatient services.* A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

*r. Certification for reimbursement as a special unit or physical rehabilitation hospital.* Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations

set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

*s. Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

*t. Limitations and application of limitations on payment.* Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

*u. State-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.

- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of  $2\frac{1}{2}$  percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2)  $2\frac{1}{2}$  percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be  $2\frac{1}{2}$  percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of  $2\frac{1}{2}$  percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of  $2\frac{1}{2}$  percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2)  $2\frac{1}{2}$  percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.



(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.
2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

*z. Final settlement for state-owned teaching hospital.*

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

*aa. Retrospective adjustment for critical access hospitals.* Payments to critical access hospitals pursuant to paragraphs 79.1(5) "a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5) "a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) "k."

*ab. Nonpayment for preventable conditions.* Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

#### Present on Admission (POA) Indicator Codes

##### Code   Explanation

- Y   The condition was present or developing at the time of the order for inpatient admission.
- N   The condition was not present or developing at the time of the order for inpatient admission.
- U   Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
- W   Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

*ac. Rural hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)“y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

**79.1(6) Independent laboratories.** The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

**79.1(7) Physicians.**

*a. Fee schedule.* The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

*b. Payment reduction for services rendered in facility settings.* The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).

(16) Comprehensive inpatient rehabilitation (POS 61).

*c. Payment for primary care services.* To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7) “c”). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7) “c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7) “c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7) “c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7) “c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7) “c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or
2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or
2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

*d. Payment for anesthesia services.* Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

**79.1(8) Drugs.**

*a.* Except as provided below in paragraphs 79.1(8)“d” through “i,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;
2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;
3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“c”; or
4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;
  2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee;
- or

3. Providers’ usual and customary charge to the general public.

*b.* For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

*c.* Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

*d.* For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the Iowa board of pharmacy's rules on return of drugs.

*e.* 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8) "a" above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

2. The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8) "a" because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

*f.* Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8) "a" above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(2) The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)“a” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug’s “best price” pursuant to 42 CFR 447.508 will be the lowest of:

- (1) The provider’s actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;
- (2) The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;
- (3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;
- (4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or
- (5) Providers’ usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“a” through “f.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Vaccines for Children Program. All providers administering vaccines available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Providers may receive Medicaid reimbursement for the administration of vaccines to Medicaid members through the otherwise applicable reimbursement for inpatient or outpatient services.

j. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)“a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

k. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

**79.1(9) *HCBS consumer choices financial management.*** Rescinded IAB 5/8/19, effective 7/1/19.

**79.1(10) *Prohibition against reassignment of claims.*** No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person’s services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent’s compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

**79.1(11) *Prohibition against factoring.*** Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

**79.1(12) *Reasonable charges for services, supplies, and equipment.*** For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

*a.* For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

*b.* For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

**79.1(13) *Copayment by member.*** A copayment in the amount specified shall be charged to members for the following covered services:

*a.* The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

*b.* The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

*c.* The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

*d.* The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

*e.* Copayment charges are not applicable to persons under age 21.

*f.* Copayment charges are not applicable to family planning services or supplies.

*g.* Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

*h.* The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.



- i.* Copayment charges are not applicable to services furnished pregnant women.
- j.* All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.
- k.* Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:
  - (1) Placing the patient's health in serious jeopardy,
  - (2) Serious impairment to bodily functions, or
  - (3) Serious dysfunction of any bodily organ or part.
- l.* Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.
- m.* No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.
- n.* The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

**79.1(14) *Reimbursement for hospice services.***

*a.* Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

*b.* Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

*c.* Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

*d.* Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect

the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

**79.1(15) HCBS retrospectively limited prospective rates.** This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. *Reporting requirements.*

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to [costaudit@dhs.state.ia.us](mailto:costaudit@dhs.state.ia.us), by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

*b. Home- and community-based general rate criteria.*

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services in the brain injury waiver.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

*c. Prospective rates for new providers.*

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

*d. Prospective rates for established providers.*

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

*e. Prospective rates for respite.* Rescinded IAB 5/1/13, effective 7/1/13.

*f. Retrospective adjustments.*

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.

*g. Supported community living daily rate.* For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

#### **79.1(16) Outpatient reimbursement for hospitals.**

*a. Definitions.*

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or "APC" means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

*“Cost outlier”* shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph “g” and are therefore eligible for additional payments above and beyond the base APC payment.

*“Current procedural terminology—fourth edition (CPT-4)”* is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

*“Diagnostic service”* means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

*“Direct medical education costs”* shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

*“Direct medical education rate”* shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

*“Discount factor”* means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

*“GME/DSH fund apportionment claim set”* means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

*“GME/DSH fund implementation year”* means 2009.

*“Graduate medical education and disproportionate share fund”* or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

*“Healthcare common procedures coding system”* or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

*“Hospital-based clinic”* means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

*“Medicaid claim set”* means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

*“Modifier”* means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

*“Multiple significant procedure discounting”* means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

*“Observation services”* means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

*“Outpatient hospital services”* means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

*“Outpatient prospective payment system”* or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

*“Outpatient visit”* shall mean those hospital-based outpatient services which are billed on a single claim form.

*“Packaged service”* means a service that is secondary to other services but is considered an integral part of another service.

*“Pass-through”* means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

*“Quality improvement organization”* or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

*“Rebasing”* shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

*“Significant procedure”* shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

*“Status indicator”* or *“SI”* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

*b. Outpatient hospital services.* Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

*c. Payment for outpatient hospital services.*

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1) “c.”

(2) Except as provided in paragraph 79.1(16) “h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16) “j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16) “e.”

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> <li>• Ambulance services.</li> <li>• Clinical diagnostic laboratory services.</li> <li>• Diagnostic mammography.</li> <li>• Screening mammography.</li> <li>• Nonimplantable prosthetic and orthotic devices.</li> <li>• Physical, occupational, and speech therapy.</li> <li>• Erythropoietin for end-stage renal dialysis (ESRD) patients.</li> <li>• Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.</li> </ul>	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) “c.”</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> <li>• May be paid when submitted on a different bill type other than outpatient hospital (13x).</li> <li>• An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.</li> </ul>
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) “c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> <li>• That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or</li> <li>• That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or</li> <li>• That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or</li> <li>• For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.</li> </ul>	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) “c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services  Corneal tissue acquisition  Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals  Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> <li>• Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established.</li> <li>• Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established.</li> </ul> If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine  Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”  If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.



Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> <li>• Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.”</li> <li>• In all other circumstances, payment is made through a separate APC payment.</li> </ul>
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> <li>• Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.”</li> <li>• In all other circumstances, payment is made through a separate APC payment.</li> </ul>
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

*d. Calculation of case-mix indices.* Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

*e. Calculation of the hospital-specific base APC rates.*

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

*f. Calculation of statewide base APC rate.*

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. *Cost outlier payment policy.* Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. *Payment to critical access hospitals.* Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. *Cost-reporting requirements.* Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

*j. Rebasing.*

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

*k. Payment to out-of-state hospitals.* Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

*l. Preadmission, preauthorization or inappropriate services.* Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

*m. Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

*n. Determination of inpatient admission.* A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

*o. Inpatient admission after outpatient services.* If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

*p. Cost report adjustments.* Rescinded IAB 6/11/03, effective 7/16/03.

*q. Determination of payment amounts for mental health noninpatient (NIP) services.* Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

*r. Services delivered in the emergency room.* Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

*s. Limit on payments.* Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

*t. Government-owned facilities.* Rescinded IAB 6/30/10, effective 7/1/10.

*u. QIO review.* The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

*v. Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

*w. Final settlement for state-owned teaching hospital.*

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

**79.1(17)** *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

**79.1(18)** *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

**79.1(19) *Reimbursement for translation and interpretation services.*** Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

*a.* For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

*b.* For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

**79.1(20) *Dentists.*** The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

**79.1(21) *Rehabilitation agencies.*** Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

**79.1(22) *Medicare crossover claims.*** Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

*a. Definitions.* For purposes of this subrule:

*"Coinsurance"* means a percentage of costs of a covered health care service that has to be paid.

*"Copayment"* means a fixed amount a member pays for a covered health care service.

*"Deductible"* means the amount paid for covered health care services before the insurance plan will effect payment.

*"Medicaid-allowed amount"* means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

*"Medicare-allowed amount"* means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

*"Medicare cost sharing"* means the Medicare member's responsibility to pay for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

*"Medicare crossover claim"* means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

*"Medicare deductible and coinsurance amounts"* means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

*"Medicare provider reimbursement"* means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.



“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

*b. Reimbursement of Medicare crossover claims.* Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

**79.1(23) *Reimbursement for remedial services.*** Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23) “c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

*a. Interim rate.* Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23) “c”(1).

*b. Cost reports.* Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

*c. Rate determination.* Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

**79.1(24) *Reimbursement for home- and community-based habilitation services.*** Reimbursement for all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

*a. Units of service.*

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

*b. Submission of cost reports.* For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24)"b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

*c. Rate determination based on cost reports.* For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

*d. Reimbursement for services provided on or after January 1, 2016.*

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

**79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).**

*a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).* Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

*b. Reimbursement methodology for community mental health centers.* Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

*c. Cost-based reimbursement.* For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

*d. Reporting requirements.* All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

**79.1(26) Home health services.**

*a.* Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

**79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.***

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or.xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to [costaudit@dhs.state.ia.us](mailto:costaudit@dhs.state.ia.us) on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

*c. Terminated home health agencies.*

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

**79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.**

*a. New providers.* Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

*b. Established providers.* After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

**79.1(29) Reimbursement for health insurance premium payment (HIPP) program providers.** Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

*a. Definitions.* For purposes of this subrule:

*"Coinsurance"* means a percentage of costs of a covered health care service that has to be paid.

*"Copayment"* means a fixed amount a member pays for a covered health care service.

*"Deductible"* means the amount paid for covered health care services before the insurance plan starts to pay.

*"Eligible member"* means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

*"Health insurance premium payment (HIPP) program"* or *"HIPP program"* has the same meaning as provided in rule 441—75.21(249A).

*b. Claim submission.* To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

**79.1(30) Tiered rates.** For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) "c" provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

*a.* Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

*b.* The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

*c.* For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

*d.* For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

*e.* Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) "f" and "g," are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

*f.* Subject to adjustment pursuant to paragraph 79.1(30) "g," acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCCL tier: Members residing in a residential-based supported community living (RBSCCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
  - g. The tier determined pursuant to paragraph 79.1(30) “f” shall be adjusted as follows:
    - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30) “e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30) “e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30) “f,” the tier is increased by one tier.
    - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30) “f,” the tier is increased by one tier.
    - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30) “f,” the tier is increased by two tiers.
    - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30) “f,” the tier is increased by one tier.
    - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
  - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
    - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
    - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
  - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,



or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1) “c.”

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2846C**, IAB 12/7/16, effective 11/15/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2930C**, IAB 2/1/17, effective 4/1/17; **ARC 2932C**, IAB 2/1/17, effective 3/8/17; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3158C**, IAB 7/5/17, effective 7/1/17; **ARC 3161C**, IAB 7/5/17, effective 7/1/17; **ARC 3162C**, IAB 7/5/17, effective 7/1/17; **ARC 3160C**, IAB 7/5/17, effective 7/1/17; **ARC 3159C**, IAB 7/5/17, effective 7/1/17; **ARC 3294C**, IAB 8/30/17, effective 10/4/17; **ARC 3295C**, IAB 8/30/17, effective 10/4/17; **ARC 3296C**, IAB 8/30/17, effective 10/4/17; **ARC 3292C**, IAB 8/30/17, effective 10/4/17; **ARC 3293C**, IAB 8/30/17, effective 10/4/17; **ARC 3481C**, IAB 12/6/17, effective 12/1/17; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 3551C**, IAB 1/3/18, effective 2/7/18; **ARC 3716C**, IAB 3/28/18, effective 5/2/18; **ARC 3790C**, IAB 5/9/18, effective 6/13/18; **ARC 4067C**, IAB 10/10/18, effective 11/14/18; **ARC 4065C**, IAB 10/10/18, effective 12/1/18; **ARC 4066C**, IAB 10/10/18, effective 12/1/18; **ARC 4068C**, IAB 10/10/18, effective 12/1/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 4974C**, IAB 3/11/20, effective 4/15/20]

#### **441—79.2(249A) Sanctions.**

##### **79.2(1) Definitions.**

“*Affiliates*” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“*Person*” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “Person” includes but is not limited to a provider and any affiliate of a provider.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

“*Provider*” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

“*Suspension of payments*” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

*“Termination from participation”* means a permanent exclusion from participation in the medical assistance program.

*“Withholding of payments”* means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

**79.2(2) Grounds for sanctions.** The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

*a.* Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

*b.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

*c.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

*d.* Upon lawful demand, failing to disclose or make available to the department, the department’s authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals’ Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

*e.* Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, “quality services” means services provided in accordance with the applicable rules and regulations governing the services.

*f.* Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

*g.* Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department’s representative or to any other publicly or privately funded health care program.

*h.* Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

*i.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

*j.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

*k.* Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

*l.* Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

*m.* Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

*n.* Exclusion from Medicare or any other state or federally funded medical assistance program.

*o.* Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

*p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

*q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

*r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

*s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

*t.* Violation of a condition of probation, suspension of payments, or other sanction.

*u.* Loss, restriction, or lack of hospital privileges for cause.

*v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

*w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

*x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

*y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

**79.2(3) *Sanctions.***

*a.* The department may impose any of the following sanctions on any person:

- (1) A term of probation for participation in the medical assistance program.
- (2) Termination from participation in the medical assistance program.
- (3) Suspension from participation in the medical assistance program.
- (4) Suspension of payments in whole or in part.
- (5) Prior authorization of services.
- (6) Review of claims prior to payment.

*b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

*c.* Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

**79.2(4) *Imposition and extent of sanction.*** The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

*a.* Seriousness of the offense.

- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

**79.2(5) *Scope of sanction.***

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

**79.2(6) *Notice to third parties.*** When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

**79.2(7) *Notice of violation.***

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

**79.2(8) *Suspension or withholding of payments.*** The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

**79.2(9) *Civil monetary penalties and interest.*** Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

**79.2(10) *Report and return of identified overpayment.***

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

*b.* A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

*c.* An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—79.3(249A) Maintenance of records by providers of service.** A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

**79.3(1) *Financial (fiscal) records.***

*a.* A provider of service shall maintain records as necessary to:

- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
- (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

*b.* A financial record does not constitute a medical record.

**79.3(2) *Medical (clinical) records.*** A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

*a. Definition.* "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

*b. Purpose.* The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

*c. Components.*

- (1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the

medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) “d.” The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Service documentation shall include narrative documentation and may also include documentation in checkbox format. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) “c” or “d,” 441—paragraph 77.33(6) “d,” 441—paragraph 77.34(5) “d,” 441—paragraph 77.37(15) “d,” 441—paragraph 77.39(13) “e,” 441—paragraph 77.39(14) “d,” or 441—paragraph 77.46(5) “i,” or 441—subparagraph 78.9(10) “a”(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

*d. Basis for service requirements for specific services.* The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2) “b.”)

- (1) Physician (MD and DO) services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
  1. Prescriptions.
  2. Nursing facility physician order.
  3. Telephone order.
  4. Pharmacy notes.
  5. Prior authorization documentation.
- (3) Dentist services:
  1. Treatment notes.
  2. Anesthesia notes and records.
  3. Prescriptions.
- (4) Podiatrist services:
  1. Service or office notes or narratives.
  2. Certifying physician statement.
  3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
  1. Service notes or narratives.
  2. Preanesthesia physical examination report.
  3. Operative report.
  4. Anesthesia record.
  5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Other service documentation as applicable.
- (7) Optometrist and optician services:
  1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
  2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
  3. Prior authorization documentation.
- (8) Psychologist services:
  1. Service or office psychotherapy notes or narratives.
  2. Psychological examination report and notes.
  3. Other service documentation as applicable.
- (9) Clinic services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Nurses’ notes.
  4. Prescriptions.
  5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
  1. Service or office notes or narratives.
  2. Form 470-2942, Prenatal Risk Assessment.
  3. Procedure, laboratory, or test orders and results.

4. Immunization records.
- (11) Services provided by community mental health centers:
  1. Service referral documentation.
  2. Initial evaluation.
  3. Individual treatment plan.
  4. Service or office notes or narratives.
  5. Narratives related to the peer review process and peer review activities related to a member's treatment.
  6. Written plan for accessing emergency services.
  7. Other service documentation as applicable.
- (12) Screening center services:
  1. Service or office notes or narratives.
  2. Immunization records.
  3. Laboratory reports.
  4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Nurses' notes.
  4. Immunization records.
  5. Consent forms.
  6. Prescriptions.
  7. Medication administration records.
- (14) Maternal health center services:
  1. Service or office notes or narratives.
  2. Procedure, laboratory, or test orders and results.
  3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
  1. Service or office notes or narratives.
  2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
  1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
  2. Physician orders.
  3. Consent forms.
  4. Anesthesia records.
  5. Pathology reports.
  6. Laboratory and X-ray reports.
- (17) Hospital services:
  1. Physician orders.
  2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
  3. Progress or status notes.
  4. Diagnostic procedures, including laboratory and X-ray reports.
  5. Pathology reports.
  6. Anesthesia records.
  7. Medication administration records.
- (18) State mental hospital services:
  1. Service referral documentation.
  2. Resident assessment and initial evaluation.
  3. Individual comprehensive treatment plan.
  4. Service notes or narratives (history and physical, therapy records, discharge summary).



5. Form 470-0042, Case Activity Report.
6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
  1. Physician orders.
  2. Progress or status notes.
  3. Service notes or narratives.
  4. Procedure, laboratory, or test orders and results.
  5. Nurses' notes.
  6. Physical therapy, occupational therapy, and speech therapy notes.
  7. Medication administration records.
  8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
  1. Physician orders.
  2. Progress or status notes.
  3. Preliminary evaluation.
  4. Comprehensive functional assessment.
  5. Individual program plan.
  6. Form 470-0374, Resident Care Agreement.
  7. Program documentation.
  8. Medication administration records.
  9. Nurses' notes.
  10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
  1. Physician orders or court orders.
  2. Independent assessment.
  3. Individual treatment plan.
  4. Service notes or narratives (history and physical, therapy records, discharge summary).
  5. Form 470-0042, Case Activity Report.
  6. Medication administration records.
- (22) Hospice services:
  1. Physician certifications for hospice care.
  2. Form 470-2618, Election of Medicaid Hospice Benefit.
  3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
  4. Plan of care.
  5. Physician orders.
  6. Progress or status notes.
  7. Service notes or narratives.
  8. Medication administration records.
  9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
  1. Physician orders.
  2. Initial certification, recertifications, and treatment plans.
  3. Narratives from treatment sessions.
  4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
  1. Notice of decision for service authorization.
  2. Service plan (initial and subsequent).
  3. Service notes or narratives.
  4. Other service documentation as applicable.
- (25) Behavioral health intervention:
  1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.
4. Other service documentation as applicable.
- (26) Services provided by area education agencies and local education agencies:
  1. Service notes or narratives.
  2. Individualized education program (IEP).
  3. Individual health plan (IHP).
  4. Behavioral intervention plan.
- (27) Home health agency services:
  1. Plan of care or plan of treatment.
  2. Certifications and recertifications.
  3. Service notes or narratives.
  4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
  1. Laboratory reports.
  2. Physician order for each laboratory test.
- (29) Ambulance services:
  1. Documentation on the claim or run report supporting medical necessity of the transport.
  2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
  1. Service notes or narratives.
  2. Child's lead level logs (including laboratory results).
  3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
  4. Health education notes, including follow-up notes.
- (31) Medical supplies:
  1. Prescriptions.
  2. Certificate of medical necessity.
  3. Prior authorization documentation.
  4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
  1. Service notes or narratives.
  2. Prescriptions.
  3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
  1. Notice of decision for service authorization.
  2. Service notes or narratives.
  3. Social history.
  4. Comprehensive service plan.
  5. Reassessment of member needs.
  6. Incident reports in accordance with 441—subrule 24.4(5).
  7. Other service documentation as applicable.
- (34) Early access service coordinator services:
  1. Individualized family service plan (IFSP).
  2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
  1. Notice of decision for service authorization.
  2. Service plan.
  3. Service logs, notes, or narratives.
  4. Mileage and transportation logs.
  5. Log of meal delivery.
  6. Invoices or receipts.

7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
8. Other service documentation as applicable.
- (36) Physical therapist services:
  1. Physician order for physical therapy.
  2. Initial physical therapy certification, recertifications, and treatment plans.
  3. Treatment notes and forms.
  4. Progress or status notes.
- (37) Chiropractor services:
  1. Service or office notes or narratives.
  2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
  1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
  2. Waiver of informed consent.
  3. Prior authorization documentation.
  4. Service or office notes or narratives.
- (39) Behavioral health services:
  1. Assessment.
  2. Individual treatment plan.
  3. Service or office notes or narratives.
  4. Other service documentation as applicable.
- (40) Health home services:
  1. Comprehensive care management plan.
  2. Care coordination and health promotion plan.
  3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
  4. Documentation of member and family support (including authorized representatives).
  5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
  1. Service or office notes or narratives.
  2. Immunization records.
  3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
  1. Department-approved standardized neurobehavioral assessment tool.
  2. Community-based neurobehavioral treatment order.
  3. Treatment plan.
  4. Clinical records documenting diagnosis and treatment history.
  5. Progress or status notes.
  6. Service notes or narratives.
  7. Procedure, laboratory, or test orders and results.
  8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
  9. Medication administration records.
  10. Other service documentation as applicable.
- (43) Child care medical services:
  1. Plan of care.
  2. Certification and recertification.
  3. Service notes or narratives.
  4. Physician orders or medical orders.
  5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).

6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. *Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

**79.3(3) Maintenance requirement.** The provider shall maintain records as required by this rule:

- a. During the time the member is receiving services from the provider.
- b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

**79.3(4) Availability.** Rescinded IAB 1/30/08, effective 4/1/08.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 4751C, IAB 11/6/19, effective 12/11/19]

#### **441—79.4(249A) Reviews and audits.**

**79.4(1) Definitions.**

"*Authorized representative,*" within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"*Claim*" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"*Clinical record*" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

*“Confidence level”* means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

*“Customary and prevailing fee”* means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

*“Extrapolation”* means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

*“Fiscal record”* means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

*“Overpayment”* means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

*“Procedure code”* means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

*“Random sample”* means a statistically valid random sample for which the probability of selection for every item in the universe is known.

*“Underpayment”* means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

*“Universe”* means all items or claims under review or audit during the period specified by the audit or review.

**79.4(2)** *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at [www.ime.state.ia.us/Providers/Forms.html](http://www.ime.state.ia.us/Providers/Forms.html), listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

**79.4(3)** *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “b.”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

**79.4(4) Preliminary report of audit or review findings.** If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

**79.4(5) Disagreement with audit or review findings.** If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not

previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

*c. Disagreement with sampling results.* When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

**79.4(6) Finding and order for repayment.** Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

**79.4(7) Appeal by provider of care.** A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

**441—79.5(249A) Nondiscrimination on the basis of handicap.** All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

**441—79.6(249A) Provider participation agreement.** Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

**79.6(1)** To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

**79.6(2)** That the charges as determined in accordance with the department’s policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

**79.6(3)** That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

**441—79.7(249A) Medical assistance advisory council.**

**79.7(1) *Officers.***

*a.* The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

*b.* The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

*c.* The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019, will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

*d.* The co-chairpersons shall appoint members to other committees approved by the council.

*e.* Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

**79.7(2) *Membership.*** The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

*a.* Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

(1) An initial election in SFY 2020 of five professional and business members shall be held. From this initial election of five members, three members with the most votes shall serve a three-year term and the other two members shall serve a two-year term. Once these members have served their initial term, the length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.



1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2) "a"(3).

b. Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a nonvoting member of the council.

d. Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

**79.7(3) Responsibilities, duties and meetings.** The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services .

a. *Recommendations.* Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. *Council.* The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

**79.7(4) Procedures.**

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members .

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

**79.7(5) Expenses, staff support, and technical assistance.** Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council .

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council .

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 8263B, IAB 11/4/09, effective 12/9/09; ARC 3006C, IAB 3/29/17, effective 6/1/17; ARC 4975C, IAB 3/11/20, effective 4/15/20]

**441—79.8(249A) Requests for prior authorization.** This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

**79.8(1) Making the request.**

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

*b.* Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

*c.* If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-0829, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-0829 the attachment control number submitted on the ASC X12N 278 electronic transaction.

**79.8(2)** The policy applies to services or items specifically designated as requiring prior authorization.

**79.8(3)** The provider shall receive a notice of approval or denial for all requests.

*a.* In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

*b.* Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

**79.8(4)** Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

**79.8(5)** Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

**79.8(6)** If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

**79.8(7)** Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

*a.* Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

*b.* When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

**79.8(8)** The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

**79.8(9)** The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

**79.8(10)** If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4973C, IAB 3/11/20, effective 4/15/20]

**441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.**

**79.9(1)** Medicare definitions and policies shall apply to services provided unless specifically defined differently.

**79.9(2)** The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

**79.9(3)** Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

**79.9(4)** Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

**79.9(5)** Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

**79.9(6)** The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

**79.9(7)** Incorrect payment.

a. Except as provided in paragraph 79.9(7) "b," medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7) "a," medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

**79.9(8)** The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320. [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

**441—79.10(249A) Requests for preadmission review.** The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

**79.10(1)** The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

**79.10(2)** Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

**79.10(3)** The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

**79.10(4)** The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

**79.10(5)** The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—79.11(249A) Requests for preprocedure surgical review.** The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

**79.11(1)** The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

**79.11(2)** The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

**79.11(3)** Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

**79.11(4)** The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

**79.11(5)** The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

**79.11(6)** The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—79.12(249A) Advance directives.** "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving

medical care through the provider or organization to comply with state law regarding advance directives as follows:

**79.12(1)** A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

**79.12(2)** The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

**79.12(3)** The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

**79.12(4)** The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

**79.12(5)** The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

**441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services.** Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

**441—79.14(249A) Provider enrollment.**

**79.14(1)** Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

*a.* Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

*b.* Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

*c.* All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

*d.* A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

*e.* An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

*f.* Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

*g.* Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

**79.14(2)** Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

*a.* The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

*b.* With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

*c.* With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

*d.* Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

**79.14(3)** Program integrity information requirements.

*a.* All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) “a”(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) “c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

**79.14(4)** Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that



was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

**79.14(5) Notification.** A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

**79.14(6)** A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

**79.14(7) Effective date of approval.** An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

**79.14(8)** A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

**79.14(9)** No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

**79.14(10)** Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

**79.14(11)** An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

**79.14(12)** A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

**79.14(13) Report of changes.** The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

*a.* When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

*b.* When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

**79.14(14) Provider termination or denial of enrollment.** The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

**79.14(15) Temporary moratoria.** The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

**79.14(16) Provider revalidation.** Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

**79.14(17) Recoupment.** A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 1153C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3494C, IAB 12/6/17, effective 1/10/18]

**441—79.15(249A) Education about false claims recovery.** The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

**79.15(1) Policy requirements.** Any entity whose medical assistance payments meet the threshold shall:

*a.* Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

*b.* Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1) "a";

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

**79.15(2) Reporting requirements.**

*a.* Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

*b.* The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

**79.15(3) Enforcement.** Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**441—79.16(249A) Electronic health record incentive program.** The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

**79.16(1) State elections.** In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

**79.16(2) Eligible providers.** To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic

when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

**79.16(3) *Application and agreement.*** Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation website, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

*a.* Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration website at [www.imeincentives.com](http://www.imeincentives.com). The applicant shall use the website to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

*b.* For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

*c.* The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

**79.16(4) *Payment.*** The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation website.

*a.* The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

*b.* Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

**79.16(5) *Administrative appeal.*** Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a.* Provider eligibility determination.
- b.* Incentive payments.
- c.* Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

**441—79.17(249A) 2013 reimbursement rate increases.** Rescinded ARC 1056C, IAB 10/2/13, effective 11/6/13.

[Filed March 11, 1970]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed 3/25/77, Notice 12/1/76—published 4/20/77, effective 5/25/77]

[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]

[Filed 10/24/77, Notice 9/7/77—published 11/16/77, effective 12/21/77]

- [Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
- [Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
- [Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
- [Filed 10/10/78, Notice 7/26/78—published 11/1/78, effective 12/6/78]
- [Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 5/23/79]
- [Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 11/7/79]
- [Filed 12/5/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]
- [Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
- [Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
- [Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
- [Filed emergency 4/23/81—published 5/13/81, effective 4/23/81]
- [Filed 8/24/81, Notice 3/4/81—published 9/16/81, effective 11/1/81]
- [Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]
- [Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
- [Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
- [Filed 7/30/82, Notice 6/9/82—published 8/18/82, effective 10/1/82]
- [Filed emergency 8/20/82 after Notice of 6/23/82—published 9/15/82, effective 10/1/82]
- [Filed 11/19/82, Notice 9/29/82—published 12/8/82, effective 2/1/83]
- [Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
- [Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
- [Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
- [Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
- [Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
- [Filed emergency 10/28/83—published 11/23/83, effective 12/1/83]
- [Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
- [Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
- [Filed 1/13/84, Notice 11/23/84—published 2/1/84, effective 3/7/84]
- [Filed 2/10/84, Notice 12/7/83—published 2/29/84, effective 5/1/84]
- [Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
- [Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
- [Filed emergency after Notice 11/1/84, Notice 7/18/84—published 11/21/84, effective 11/1/84]
- [Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
- [Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
- [Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
- [Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
- [Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
- [Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
- [Filed 12/2/85, Notice 10/9/85—published 12/18/85, effective 2/1/86]
- [Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
- [Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
- [Filed 2/21/86, Notices 12/18/85, 1/15/86—published 3/12/86, effective 5/1/86]
- [Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
- [Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
- [Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
- [Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
- [Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
- [Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
- [Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
- [Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
- [Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
- [Filed 10/23/87, Notice 8/26/87—published 11/18/87, effective 1/1/88]
- [Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]

- [Filed 11/30/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
- [Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]<sup>1</sup>
- [Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
- [Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
- [Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]<sup>2,4</sup>
- [Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
- [Filed emergency 10/28/88—published 11/16/88, effective 11/1/88]
- [Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
- [Filed emergency 12/22/88 after Notice of 11/16/88—published 1/11/89, effective 1/1/89]
- [Filed 12/22/88, Notices 11/16/88<sup>2,4</sup>—published 1/11/89, effective 3/1/89]
- [Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
- [Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
- [Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
- [Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
- [Filed emergency 1/10/90 after Notice of 10/4/89—published 1/10/90, effective 1/1/90]
- [Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90]<sup>3</sup>
- [Filed emergency 2/14/90—published 3/7/90, effective 4/1/90]
- [Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
- [Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
- [Filed emergency 5/11/90—published 5/30/90, effective 6/1/90]
- [Filed 5/11/90, Notice 4/4/90—published 5/30/90, effective 8/1/90]
- [Filed emergency 6/14/90 after Notice 5/2/90—published 7/11/90, effective 7/1/90]
- [Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
- [Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
- [Filed 8/16/90, Notices 7/11/90<sup>2,4</sup>—published 9/5/90, effective 11/1/90]
- [Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
- [Filed emergency 1/17/91 after Notice 11/28/90—published 2/6/91, effective 2/1/91]
- [Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
- [Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
- [Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
- [Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
- [Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
- [Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
- [Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91]<sup>5</sup>
- [Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
- [Filed emergency 9/18/91 after Notice 7/24/91—published 10/16/91, effective 10/1/91]
- [Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
- [Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
- [Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
- [Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]<sup>6</sup>
- [Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
- [Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
- [Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
- [Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
- [Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
- [Filed without Notice 6/11/92—published 7/8/92, effective 9/1/92]
- [Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
- [Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
- [Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
- [Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
- [Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]

[Filed emergency 12/30/92 after Notice 11/25/92—published 1/20/93, effective 1/1/93]  
     [Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]  
     [Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]  
     [Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]  
 [Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]  
     [Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]  
     [Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]  
     [Filed 6/11/93, Notice 4/28/93—published 7/7/93, effective 9/1/93]  
     [Filed emergency 6/25/93—published 7/21/93, effective 7/1/93]  
 [Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]  
     [Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]  
 [Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]  
     [Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]  
     [Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]  
     [Filed 11/12/93, Notice 9/29/93—published 12/8/93, effective 2/1/94]  
     [Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]  
     [Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]  
 [Filed 3/10/94, Notices 1/19/94, 2/2/94—published 3/30/94, effective 6/1/94]<sup>24</sup>  
     [Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]  
     [Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]  
     [Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]  
 [Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/1/95]  
     [Filed 3/20/95, Notice 2/1/95—published 4/12/95, effective 6/1/95]  
     [Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]  
     [Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]  
     [Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]  
 [Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96]<sup>24</sup>  
     [Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]  
     [Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]  
     [Filed 7/10/96, Notice 6/5/96—published 7/31/96, effective 10/1/96]  
     [Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]  
     [Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]  
     [Filed 11/13/96, Notice 9/11/96—published 12/4/96, effective 2/1/97]  
     [Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]  
     [Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]  
     [Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]  
 [Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]  
     [Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]  
     [Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]  
     [Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]  
     [Filed emergency 11/12/97—published 12/3/97, effective 11/12/97]  
     [Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]  
 [Filed 1/14/98, Notices 11/19/97, 12/3/97—published 2/11/98, effective 4/1/98]  
     [Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]  
     [Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]  
     [Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]  
     [Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]  
     [Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]  
     [Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]  
     [Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]  
     [Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]  
     [Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]

[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]  
 [Filed 6/10/99, Notice 5/5/99—published 6/30/99, effective 9/1/99]  
 [Filed 7/15/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]  
 [Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]  
 [Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]  
 [Filed 4/12/00, Notice 2/9/00—published 5/3/00, effective 7/1/00]  
 [Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]  
 [Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]  
 [Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]  
 [Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]  
 [Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]  
 [Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]  
 [Filed 11/8/00, Notice 9/20/00—published 11/29/00, effective 2/1/01]  
 [Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]  
 [Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]  
 [Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]  
 [Filed 5/9/01, Notice 4/4/01—published 5/30/01, effective 8/1/01]  
 [Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]  
 [Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]<sup>24</sup>  
 [Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]  
 [Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]  
 [Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]  
 [Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]<sup>24</sup>  
 [Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]  
 [Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]  
 [Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]<sup>7</sup>  
 [Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]  
 [Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]  
 [Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]  
 [Filed 4/10/02, Notice 2/6/02—published 5/1/02, effective 7/1/02]  
 [Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]<sup>8</sup>  
 [Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]  
 [Filed 8/15/02, Notice 6/12/02—published 9/4/02, effective 11/1/02]  
 [Filed 8/15/02, Notice 6/26/02—published 9/4/02, effective 11/1/02]  
 [Filed emergency 9/12/02—published 10/2/02, effective 9/12/02]  
 [Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]  
 [Filed 11/18/02, Notice 10/2/02—published 12/11/02, effective 2/1/03]  
 [Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]  
 [Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]  
 [Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]<sup>24</sup>  
 [Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]<sup>24</sup>  
 [Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]<sup>24</sup>  
 [Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]  
 [Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]  
 [Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]  
 [Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]<sup>24</sup>  
 [Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]  
 [Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]<sup>24</sup>  
 [Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]  
 [Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]  
 [Filed emergency 6/17/05—published 7/6/05, effective 6/25/05]  
 [Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]<sup>24</sup>



- [Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
- [Filed emergency 10/21/05 after Notice 7/6/05—published 11/9/05, effective 10/21/05]
- [Filed 10/21/05, Notices 5/11/05 and 7/6/05<sup>7</sup>—published 11/9/05, effective 12/14/05]
- [Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
- [Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
- [Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
- [Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
- [Filed 6/16/06, Notice 4/26/06—published 7/5/06, effective 9/1/06]
- [Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
- [Filed 8/10/06, Notice 2/15/06—published 8/30/06, effective 11/1/06]
- [Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
- [Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
- [Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
- [Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
- [Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
- [Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
- [Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
- [Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
- [Filed emergency 8/9/07 after Notice 7/4/07—published 8/29/07, effective 8/10/07]
- [Filed 8/9/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]
- [Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
- [Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
- [Filed emergency 10/10/07—published 11/7/07, effective 10/10/07]
- [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
- [Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
- [Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
- [Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
- [Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
- [Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
- [Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
- [Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
- [Filed ARC 7835B (Notice ARC 7627B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
- [Filed Emergency ARC 7937B, IAB 7/1/09, effective 7/1/09]
- [Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]<sup>10</sup>
- [Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
- [Filed ARC 8206B (Notice ARC 7938B, IAB 7/1/09), IAB 10/7/09, effective 11/11/09]
- [Filed ARC 8262B (Notice ARC 8084B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
- [Filed ARC 8263B (Notice ARC 8059B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
- [Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
- [Filed Emergency ARC 8647B, IAB 4/7/10, effective 3/11/10]
- [Filed Emergency ARC 8649B, IAB 4/7/10, effective 3/11/10]
- [Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
- [Filed Emergency ARC 8894B, IAB 6/30/10, effective 7/1/10]
- [Filed Emergency ARC 8899B, IAB 6/30/10, effective 7/1/10]
- [Filed Emergency ARC 9046B, IAB 9/8/10, effective 8/12/10]
- [Filed ARC 9127B (Notice ARC 8896B, IAB 6/30/10), IAB 10/6/10, effective 11/10/10]
- [Filed Emergency ARC 9134B, IAB 10/6/10, effective 10/1/10]
- [Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
- [Filed ARC 9176B (Notice ARC 8900B, IAB 6/30/10), IAB 11/3/10, effective 12/8/10]
- [Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]

- [Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]  
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]  
[Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]  
[Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]  
[Filed Emergency After Notice ARC 9531B (Notice ARC 9431B, IAB 3/23/11), IAB 6/1/11, effective 5/12/11]  
[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]  
[Filed Emergency ARC 9706B, IAB 9/7/11, effective 8/17/11]  
[Filed Emergency ARC 9708B, IAB 9/7/11, effective 8/17/11]  
[Filed Emergency ARC 9710B, IAB 9/7/11, effective 8/17/11]  
[Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9712B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9714B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9719B, IAB 9/7/11, effective 9/1/11]  
[Filed Emergency ARC 9722B, IAB 9/7/11, effective 9/1/11]  
[Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9886B (Notice ARC 9713B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9887B (Notice ARC 9715B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]  
[Filed ARC 9958B (Notice ARC 9707B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]  
[Filed ARC 9959B (Notice ARC 9721B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]  
[Filed ARC 9960B (Notice ARC 9723B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]  
[Filed Emergency ARC 9996B, IAB 2/8/12, effective 1/19/12]  
[Filed ARC 0028C (Notice ARC 9711B, IAB 9/7/11), IAB 3/7/12, effective 4/11/12]  
[Filed ARC 0029C (Notice ARC 9709B, IAB 9/7/11), IAB 3/7/12, effective 4/11/12]  
[Nullified amendment editorially removed, IAC Supplement 5/16/12]<sup>ii</sup>  
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency ARC 0196C, IAB 7/11/12, effective 7/1/12]  
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]  
[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]  
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0355C (Notice ARC 0197C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]  
[Filed ARC 0485C (Notice ARC 0259C, IAB 8/8/12), IAB 12/12/12, effective 2/1/13]  
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]  
[Filed Emergency ARC 0548C, IAB 1/9/13, effective 1/1/13]  
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]  
[Filed ARC 0581C (Notice ARC 0436C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]  
[Filed Emergency ARC 0585C, IAB 2/6/13, effective 1/9/13]  
[Filed ARC 0665C (Notice ARC 0547C, IAB 1/9/13), IAB 4/3/13, effective 6/1/13]  
[Filed ARC 0708C (Notice ARC 0568C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0711C (Notice ARC 0570C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0712C (Notice ARC 0569C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0710C (Notice ARC 0588C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0713C (Notice ARC 0584C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]  
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]  
[Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]  
[Filed ARC 0824C (Notice ARC 0669C, IAB 4/3/13), IAB 7/10/13, effective 9/1/13]

- [Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0840C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0864C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
- [Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
- [Filed ARC 1058C (Notice ARC 0863C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1057C (Notice ARC 0839C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
- [Filed ARC 1150C (Notice ARC 0918C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1152C (Notice ARC 0910C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1154C (Notice ARC 0919C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1155C (Notice ARC 0912C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1153C (Notice ARC 0917C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
- [Filed ARC 1481C (Notice ARC 1391C, IAB 4/2/14), IAB 6/11/14, effective 8/1/14]
- [Filed Emergency ARC 1519C, IAB 7/9/14, effective 7/1/14]
- [Filed Emergency ARC 1521C, IAB 7/9/14, effective 7/1/14]
- [Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]
- [Filed ARC 1609C (Notice ARC 1518C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
- [Filed ARC 1608C (Notice ARC 1520C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
- [Filed ARC 1695C (Notice ARC 1621C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1697C (Notice ARC 1619C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1699C (Notice ARC 1617C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1977C (Notice ARC 1818C, IAB 1/7/15), IAB 4/29/15, effective 7/1/15]
- [Filed ARC 2026C (Notice ARC 1921C, IAB 3/18/15), IAB 6/10/15, effective 8/1/15]
- [Filed Emergency ARC 2075C, IAB 8/5/15, effective 7/15/15]
- [Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
- [Filed ARC 2167C (Notice ARC 2076C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
- [Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
- [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
- [Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
- [Filed Emergency ARC 2846C, IAB 12/7/16, effective 11/15/16]
- [Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
- [Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
- [Filed ARC 2932C (Notice ARC 2847C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
- [Filed ARC 3006C (Notice ARC 2899C, IAB 1/18/17), IAB 3/29/17, effective 6/1/17]
- [Filed Emergency ARC 3158C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3161C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3162C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3160C, IAB 7/5/17, effective 7/1/17]
- [Filed Emergency ARC 3159C, IAB 7/5/17, effective 7/1/17]
- [Filed ARC 3292C (Notice ARC 3164C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]
- [Filed ARC 3293C (Notice ARC 3166C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]

[Filed ARC 3294C (Notice ARC 3165C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
 [Filed ARC 3295C (Notice ARC 3167C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
 [Filed ARC 3296C (Notice ARC 3163C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]  
     [Filed Emergency ARC 3358C, IAB 10/11/17, effective 10/1/17]  
     [Filed Emergency ARC 3481C, IAB 12/6/17, effective 12/1/17]  
 [Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]  
     [Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]  
     [Filed ARC 3554C (Notice ARC 3357C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]  
     [Filed ARC 3716C (Notice ARC 3598C, IAB 1/31/18), IAB 3/28/18, effective 5/2/18]  
 [Filed ARC 3790C (Notice ARC 3476C, IAB 12/6/17; Amended Notice ARC 3602C, IAB 1/31/18),  
     IAB 5/9/18, effective 6/13/18]  
 [Filed ARC 4067C (Notice ARC 3923C, IAB 8/1/18), IAB 10/10/18, effective 11/14/18]  
 [Filed ARC 4065C (Notice ARC 3911C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]  
 [Filed ARC 4066C (Notice ARC 3909C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]  
 [Filed ARC 4068C (Notice ARC 3906C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]  
     [Filed ARC 4430C (Notice ARC 4288C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]<sup>12</sup>  
 [Filed ARC 4751C (Notice ARC 4600C, IAB 8/14/19), IAB 11/6/19, effective 12/11/19]  
 [Filed ARC 4899C (Notice ARC 4763C, IAB 11/20/19), IAB 2/12/20, effective 3/18/20]<sup>13</sup>  
     [Filed ARC 4973C (Notice ARC 4675C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]  
     [Filed ARC 4974C (Notice ARC 4819C, IAB 12/18/19), IAB 3/11/20, effective 4/15/20]  
     [Filed ARC 4975C (Notice ARC 4818C, IAB 12/18/19), IAB 3/11/20, effective 4/15/20]

<sup>1</sup> Effective date of 79.1(2) and 79.1(5) “t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

<sup>2</sup> Two ARCs

<sup>3</sup> Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

<sup>4</sup> Two or more ARCs

<sup>5</sup> Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

<sup>6</sup> Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

<sup>7</sup> At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

<sup>8</sup> Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

<sup>9</sup> Two ARCs

<sup>10</sup> July 1, 2009, effective date of amendments to 79.1(1) “d,” 79.1(2), and 79.1(24) “a”(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

<sup>11</sup> See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) “b” (ARC 9959B, IAB 1/11/12).

<sup>12</sup> July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

<sup>13</sup> March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020.

CHAPTER 182  
PRACTICE OF OPTOMETRISTS

[Prior to 8/7/02, see 645—179.4(154), 179.5(154,272C), 179.7(154) and 179.8(155A)]

**645—182.1(154) Code of ethics.** The board hereby adopts by reference the Code of Ethics of the American Optometric Association as published by the American Optometric Association, 243 North Lindbergh Boulevard, St. Louis, Missouri 63141, modified June 2007.

[ARC 9641B, IAB 7/27/11, effective 8/31/11]

**645—182.2(154,272C) Record keeping.** Optometrists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Records shall be permanent, timely, accurate, legible, and easily understandable.

**182.2(1)** Optometrists shall maintain optometry records for each patient. The records shall contain all of the following:

*a. Personal data.*

- (1) Name, date of birth, address and, if a minor, name of parent or guardian; and
- (2) Name and telephone number of person to contact in case of emergency.

*b. Optometry and medical history.* Optometry records shall include information from the patient or the patient's parent or guardian regarding the patient's optometric and medical history. The information shall include sufficient data to support the recommended treatment plan.

*c. Patient's reason for visit.* When a patient presents with a chief complaint, optometric records shall include the patient's stated visual health care reasons for visiting the optometrist.

*d. Clinical examination progress notes.* Optometric records shall include chronological dates and descriptions of the following:

- (1) Clinical examination findings, tests conducted, and a summary of all pertinent diagnoses;
- (2) Plan of intended treatment and treatment sequence;
- (3) Services rendered and any treatment complications;
- (4) All ancillary testing, if applicable;
- (5) Vision tests completed and visual acuity;
- (6) Name, quantity, and strength of all drugs dispensed, administered, or prescribed; and
- (7) Name of optometrist who performs any treatment or service or who may have contact with a patient regarding the patient's optometric health.

*e. Informed consent.* Optometric records shall include documentation of informed consent for procedure(s) and treatment that have potential serious complications and known risks.

**182.2(2)** Retention of records. An optometrist shall maintain a patient's record(s) for a minimum of five years after the date of last examination, prescription, or treatment. Records for minors shall be maintained for, at minimum, one year after the patient reaches the age of majority (18) or five years after the date of last examination, prescription, or treatment, whichever is longer.

Proper safeguards shall be maintained to ensure the safety of records from destructive elements.

**182.2(3)** Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, an optometrist shall keep either a duplicate hard-copy record or a back-up unalterable electronic record.

**182.2(4)** Correction of records. Notations shall be legible, written in ink, and contain no erasures or white-outs. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line and be initialed by an optometric health care worker.

**182.2(5)** Confidentiality and transfer of records. Optometrists shall preserve the confidentiality of patient records in a manner consistent with the protection of the welfare of the patient. Upon request of the patient or the patient's new optometrist, the optometrist shall furnish such optometry records or copies of the records as will be beneficial for the future treatment of that patient. The optometrist may include a summary of the record(s) with the record(s) or copy of the record(s). The optometrist may charge a nominal fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees. The optometrist may ask for a written request for the record(s).

**182.2(6)** Retirement or discontinuance of practice. A licensee, upon retirement, or upon discontinuation of the practice of optometry, or upon leaving a practice or moving from a community, shall notify all active patients in writing, or by publication once a week for three consecutive weeks in a newspaper of general circulation in the community, that the licensee intends to discontinue the practice of optometry in the community, and shall encourage patients to seek the services of another licensee. The licensee shall make reasonable arrangements with active patients for the transfer of patient records, or copies of those records, to the succeeding licensee. "Active patient" means a person whom the licensee has examined, treated, cared for, or otherwise consulted with during the two-year period prior to retirement, discontinuation of the practice of optometry, or leaving a practice or moving from a community.

**182.2(7)** Nothing stated in these rules shall prohibit a licensee from conveying or transferring the licensee's patient records to another licensed optometrist who is assuming a practice, provided that written notice is furnished to all patients.

**645—182.3(154) Furnishing prescriptions.** Before a licensed optometrist provides a spectacle or contact lens prescription to a patient, the eye examination record shall include best-corrected visual acuity with ophthalmic lenses or contact lenses in the lens powers determined by refraction. Each contact lens or ophthalmic spectacle lens/eyeglass prescription by a licensed optometrist must meet the requirements as listed below:

**182.3(1)** A contact lens prescription shall contain the following information:

- a. Date of issuance;
- b. Name and address of patient for whom the contact lens or lenses are prescribed;
- c. Name, address, and signature of the practitioner;
- d. All parameters required to duplicate properly the original contact lens;
- e. A specific date of expiration, not to exceed 18 months, the quantity of lenses allowed and the number of refills allowed; and
- f. At the option of the prescribing practitioner, the prescription may contain fitting and material guidelines and specific instructions for use by the patient.

**182.3(2)** Release of contact lens prescription.

a. After the contact lenses have been adequately adapted and the patient released from initial follow-up care by the prescribing practitioner, the prescribing practitioner shall, upon request of the patient, provide a copy of the contact lens prescription, at no cost, for the duplication of the original contact lens.

b. A practitioner choosing to issue an oral prescription shall furnish the same information required for the written prescription except for the written signature and address of the practitioner. An oral prescription may be released by an O.D. to any dispensing person who is a licensed professional with the O.D., M.D., D.O., or R.Ph. degree or a person under direct supervision of those licensed under Iowa Code chapter 148, 154 or 155A.

c. The issuing of an oral prescription must be followed by a written copy to be kept by the dispenser of the contact lenses until the date of expiration.

**182.3(3)** An ophthalmic spectacle lens prescription shall contain the following information:

- a. Date of issuance;
- b. Name and address of the patient for whom the ophthalmic lens or lenses are prescribed;
- c. Name, address, and signature of the practitioner issuing the prescription;
- d. All parameters necessary to duplicate properly the ophthalmic lens prescription; and
- e. A specific date of expiration not to exceed two years.
- f. A dispenser of ophthalmic materials, in spectacle or eyeglass form, must keep a valid copy of the prescription on file for two years.

**182.3(4)** Release of ophthalmic lens prescription.

a. The ophthalmic lens prescription shall be furnished upon request at no additional charge to the patient.

b. The prescription, at the option of the prescriber, may contain adapting and material guidelines and may also contain specific instructions for use by the patient.

c. Spectacle lens prescriptions must be in written format, according to Iowa Code section 147.109(1).

[ARC 9641B, IAB 7/27/11, effective 8/31/11; ARC 3428C, IAB 10/25/17, effective 11/29/17]

**645—182.4(155A) Prescription drug orders.** Each prescription drug order furnished by an optometrist in this state shall meet the following requirements:

**182.4(1)** Written prescription drug orders shall contain:

- a. The date of issuance;
- b. The name and address of the patient for whom the drug is dispensed;
- c. The name, strength, and quantity of the drug, medicine, or device prescribed;
- d. The directions for use of the drug, medicine, or device prescribed;
- e. The name, address, and written signature of the practitioner issuing the prescription; and
- f. The federal drug enforcement administration number, if required under Iowa Code chapter 124.

**182.4(2)** The practitioner issuing oral prescription drug orders shall furnish the same information required for a written prescription, except for the written signature and address of the practitioner.

**182.4(3)** Prior to prescribing any controlled substance, an optometrist shall review the patient's information contained in the prescription monitoring program database, unless the patient is receiving inpatient hospice care or long-term residential facility care.

**182.4(4)** Beginning January 1, 2020, every prescription issued for a prescription drug shall be transmitted electronically unless exempted pursuant to Iowa Code sections 124.308 or 155A.27. Beginning January 1, 2020, a licensee who fails to comply with the electronic prescription mandate may be subject to a nondisciplinary administrative penalty of \$250 per violation, up to a maximum of \$5,000 per calendar year.

[ARC 9641B, IAB 7/27/11, effective 8/31/11; ARC 0899C, IAB 8/7/13, effective 9/11/13; ARC 4951C, IAB 2/26/20, effective 4/1/20; ARC 5160C, IAB 8/26/20, effective 9/30/20]

These rules are intended to implement Iowa Code chapters 154 and 155A.

[Filed 7/18/02, Notice 5/15/02—published 8/7/02, effective 9/11/02]

[Filed ARC 9641B (Notice ARC 9519B, IAB 5/18/11), IAB 7/27/11, effective 8/31/11]

[Filed ARC 0899C (Notice ARC 0680C, IAB 4/3/13), IAB 8/7/13, effective 9/11/13]

[Filed ARC 3428C (Notice ARC 3223C, IAB 8/2/17), IAB 10/25/17, effective 11/29/17]

[Filed ARC 4951C (Notice ARC 4668C, IAB 9/25/19), IAB 2/26/20, effective 4/1/20]

[Filed ARC 5160C (Notice ARC 5003C, IAB 3/25/20), IAB 8/26/20, effective 9/30/20]





## SPEECH PATHOLOGISTS AND AUDIOLOGISTS

CHAPTER 300	LICENSURE OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS
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CHAPTER 300  
LICENSURE OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

**645—300.1(147) Definitions.** For purposes of these rules, the following definitions shall apply:

*“Active license”* means a license that is current and has not expired.

*“ASHA”* means the American Speech-Language Hearing Association.

*“Assistant”* means an unlicensed person who works under the supervision of an Iowa-licensed speech pathologist or audiologist and meets the minimum requirements set forth in these rules.

*“Audiologist”* means a person who engages in the application of principles, methods and procedures for measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, rehabilitation, or remediation related to hearing and disorders of hearing and associated communication disorders for the purpose of nonmedically evaluating, identifying, preventing, ameliorating, modifying, or remediating such disorders and conditions in individuals or groups of individuals, including the determination and use of appropriate amplification.

*“Board”* means the board of speech pathology and audiology.

*“Full-time”* means a minimum of 30 hours per week.

*“Grace period”* means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

*“Inactive license”* means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

*“Licensee”* means any person licensed to practice as a speech pathologist or audiologist in the state of Iowa.

*“License expiration date”* means December 31 of odd-numbered years.

*“Licensure by endorsement”* means the issuance of an Iowa license to practice speech pathology or audiology to an applicant who is or has been licensed in another state.

*“On site”* means:

1. To be continuously on site and present in the department or facility where services are being provided;
2. To be immediately available to assist the person being supervised in the services being performed; and
3. To provide continued direction of appropriate aspects of each treatment session in which a component of treatment is delegated.

*“Reactivate”* or *“reactivation”* means the process as outlined in rule 645—300.17(17A,147,272C) by which an inactive license is restored to active status.

*“Reciprocal license”* means the issuance of an Iowa license to practice speech pathology or audiology to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board of speech pathology and audiology to license persons that have the same or similar qualifications to those required in Iowa.

*“Reinstatement”* means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the

license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

*“Speech pathologist”* means a person who engages in the application of principles, methods, and procedures for the measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, rehabilitation, or remediation related to the development and disorders of speech, fluency, voice, or language for the purpose of nonmedically evaluating, preventing, ameliorating, modifying, or remediating such disorders and conditions in individuals or groups of individuals.

[ARC 3591C, IAB 1/17/18, effective 2/21/18]

**645—300.2(147) Speech pathology and audiology services subject to regulation.** The provision of speech pathology or audiology services in Iowa through telephonic, electronic, or other means, regardless of the location of the speech/language pathologist or audiologist, shall constitute the practice of speech pathology or audiology and shall require Iowa licensure.

**645—300.3(147) Requirements for licensure.** The following criteria shall apply to licensure:

**300.3(1)** The applicant shall complete a board-approved application packet. Application forms may be obtained from the board’s website ([www.idph.iowa.gov/licensure](http://www.idph.iowa.gov/licensure)) or directly from the board office. All applications shall be sent to Board of Speech Pathology and Audiology, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

**300.3(2)** The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

**300.3(3)** Each application shall be accompanied by the appropriate fees payable to the Board of Speech Pathology and Audiology. The fees are nonrefundable.

**300.3(4)** The application shall include:

- a.* An official copy of a current ASHA certificate of clinical competence; or
- b.* Submission of the following:

(1) Official copies of academic transcripts sent directly from the school to the board showing proof of possession of a master’s degree in speech pathology or a master’s or doctoral degree in audiology or the equivalent of one of these degrees and official verification of completion of not less than 400 hours of supervised clinical training;

(2) Verification of nine months of full-time clinical experience, or equivalent, completed after the master’s degree, under the supervision of a licensed speech pathologist or audiologist or as a part of the doctoral degree; and

(3) Results of the Praxis Examination.

**300.3(5)** Licensees who were issued their licenses within six months prior to the renewal shall not be required to renew their licenses until the renewal date two years later.

**300.3(6)** Incomplete applications that have been on file in the board office for more than two years shall be:

- a.* Considered invalid and shall be destroyed; or
- b.* Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

[ARC 1397C, IAB 4/2/14, effective 5/7/14; ARC 3591C, IAB 1/17/18, effective 2/21/18]

**645—300.4(147) Educational qualifications.**

**300.4(1)** The applicant shall possess the following:

*a.* A master’s degree from an accredited school, college or university with a major in speech pathology; or

*b.* A master’s or doctoral degree from an accredited school, college or university with a major in audiology.

**300.4(2)** Foreign-trained speech pathologists and audiologists shall:

*a.* Provide an equivalency evaluation of their educational credentials by one of the following: International Education Research Foundation, Inc., Credentials Evaluation Service, P.O. Box 3665,

Culver City, CA 90231-3665, telephone (310)258-9451, website [www.ierf.org](http://www.ierf.org) or email at [info@ierf.org](mailto:info@ierf.org); International Credentialing Associates, Inc., 10801 Starkey Road, Suite 104 #108, Seminole, FL 33777, telephone (727)549-8555 or website [www.icaworld.com](http://www.icaworld.com). The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

*b.* Receive a final determination from the board regarding the application for licensure.

[ARC 3591C, IAB 1/17/18, effective 2/21/18]

**645—300.5(147) Examination requirements.** The examination required by the board shall be the Praxis Examination in speech pathology or audiology. This examination is administered by the Educational Testing Service.

**300.5(1)** The applicant has full responsibility for making arrangements to take the Praxis Examination in speech pathology or audiology and for bearing all expenses associated with taking the examination. The applicant also has the responsibility for having the examination scores sent directly to the board from the Educational Testing Service.

**300.5(2)** The board shall determine the qualifying scores for both the speech pathology and audiology examinations.

[ARC 1397C, IAB 4/2/14, effective 5/7/14]

**645—300.6(147) Temporary clinical license.** A temporary clinical license for the purpose of obtaining clinical experience as a prerequisite for licensure is valid for one year and may be renewed at the discretion of the board. The license shall be designated “temporary clinical license in speech pathology” or “temporary clinical license in audiology.”

**300.6(1)** A speech pathology applicant must submit the following to the board:

- a.* Evidence of supervision by a speech pathologist with an active, current Iowa license in good standing;
- b.* An official application form provided by the board and completed by the applicant;
- c.* An official copy of the transcript, sent directly from the school to the board, showing proof of possession of a master’s degree in speech pathology;
- d.* Official verification of completion of not less than 400 hours of supervised clinical training in an accredited college or university;
- e.* The temporary clinical license fee; and
- f.* Results of the Praxis Examination.

**300.6(2)** An audiology applicant or an applicant completing a doctoral externship must submit the following to the board:

- a.* Evidence of supervision by an audiologist with an active, current Iowa license in good standing. The applicant completing an audiology doctoral externship must show evidence of on-site supervision;
- b.* An official application form provided by the board and completed by the applicant;
- c.* An official copy of the transcript, sent directly from the school to the board, showing proof of possession of a master’s degree in audiology;
- d.* Official verification of completion of not less than 400 hours of supervised clinical training in an accredited college or university;
- e.* The temporary clinical license fee; and
- f.* Results of the Praxis Examination.

**300.6(3)** The plan for supervised clinical experience must be approved by the board before the applicant starts practice and shall:

- a.* Include at least nine months of full-time clinical experience, or equivalent;
- b.* Include supervision by an Iowa-licensed speech pathologist or audiologist, as appropriate. If the applicant is being supervised by more than one individual, each supervisor must submit a supervised clinical experience plan for approval. If there is a change in the supervised clinical experience plan at any time during the supervised clinical experience, the licensee must contact the board for approval within 30 days of the change;
- c.* Be kept by the supervisor for two years from the last date of the clinical experience; and

d. Include a completed supervised clinical experience report form that shall be submitted to the board of speech pathology and audiology upon the applicant's successful completion of the nine months of full-time clinical experience. If the applicant was supervised by more than one individual, each supervisor must submit a supervised clinical experience report. The applicant may then apply for licensure.

[ARC 8872B, IAB 6/30/10, effective 8/4/10; ARC 1397C, IAB 4/2/14, effective 5/7/14; ARC 3591C, IAB 1/17/18, effective 2/21/18]

**645—300.7(147) Temporary permit.**

**300.7(1)** A nonresident may apply to the board for a temporary permit to practice speech pathology or audiology:

- a. For a period not to exceed three months;
- b. By submitting a letter to support the need for such a permit;
- c. By submitting documents to show that the applicant has substantially the same qualifications as required for licensure in Iowa;
- d. By submitting the documentation prior to the date the applicant intends to begin practice; and
- e. By submitting the temporary permit fee.

**300.7(2)** The applicant shall receive a final determination from the board regarding the application for a temporary permit.

**645—300.8(147) Use of assistants.** A licensee shall, in the delivery of professional services, utilize assistants only to the extent provided in these rules. Such assistants shall use the title provided by these rules.

**300.8(1) Duties.**

- a. *Speech pathology assistant I.* A speech pathology assistant I works with an individual for whom significant improvement is expected within a reasonable amount of time.
- b. *Speech pathology assistant II.* A speech pathology assistant II works with an individual for whom maintenance of present level of communication is the goal; or for whom, based on the history and diagnosis, only slow improvement is expected.
- c. *Audiology assistant I.* An audiology assistant I is more broadly trained and may be given a variety of duties depending upon the individual's training.
- d. *Audiology assistant II.* An audiology assistant II is trained specifically for a single task for screening.

**300.8(2) Minimum requirements.**

a. A speech pathology assistant I or II or audiology assistant I must satisfy the following minimum requirements:

- (1) Reach the age of majority;
- (2) Complete a high school education, or its equivalent; and
- (3) Complete one of the following:
  1. A three-semester-hour (or four-quarter-hour) course in introductory speech and language pathology for speech pathology assistants or in audiology for audiology assistants from an accredited educational institution and 15 hours of instruction in the specific tasks which the assistant will be performing; or
  2. A minimum training period comprised of 75 clock hours on instruction and practicum experience.

b. An audiology assistant II must satisfy the following requirements:

- (1) Reach the age of majority.
- (2) Complete a high school education, or its equivalent.
- (3) Complete a minimum of 15 clock hours of instruction and practicum experience in the specific task which the assistant will be performing.

**300.8(3) Utilization.** Utilization of a speech pathology or audiology assistant requires that a plan be developed by the licensee desiring to utilize that assistant, consisting of the following information:

- a. Documentation that the assistant meets minimum requirements;

b. A written plan of the activities and supervision that must be kept by the licensee supervising the assistant. This supervision must include direct on-site observation for a minimum of 20 percent of the assistant's direct patient care for level I speech pathology and level I audiology assistants and 10 percent for level II speech pathology assistants. Level II audiology assistants must be supervised 10 percent of the time. At least half of that time must be direct on-site observation with the other portion provided as time interpreting results;

c. A listing of the facilities where the assistant will be utilized; and

d. A statement, signed by the licensee and the assistant, that the rules pertaining to assistants have been read by both.

**300.8(4) *Maximum number of assistants.*** A licensee may not utilize more than three assistants unless a plan of supervision is filed and approved by the board.

**300.8(5) *Supervisor responsibilities.*** A licensee who utilizes an assistant shall have the following responsibilities:

a. To be legally responsible for the actions of the assistant in that assistant's performance of assigned duties with a client;

b. To make all professional decisions relating to the management of a client;

c. To ensure that the assistant is assigned only those duties and responsibilities for which the assistant has been specifically trained and is qualified to perform;

d. To ensure compliance of the assistant(s) under supervision with the provisions of these rules by providing periodic direct observation and supervision of the activities of the assistant; and

e. To submit to the board of speech pathology and audiology upon request a copy of the plan of activities and supervision for each assistant and documentation of the dates each assistant was utilized by the licensee.

[ARC 3591C, IAB 1/17/18, effective 2/21/18]

#### **645—300.9(147) Licensure by endorsement.**

**300.9(1)** The board may issue a license by endorsement to any applicant from the District of Columbia or another state, territory, province or foreign country who has been a licensed speech pathologist or audiologist under the laws of another jurisdiction.

**300.9(2)** The applicant shall complete a board-approved application packet. Application forms may be obtained from the board's website ([www.idph.iowa.gov/licensure](http://www.idph.iowa.gov/licensure)) or directly from the board office. All applications shall be sent to Board of Speech Pathology and Audiology, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075. Each application shall be submitted with the following:

a. Payment of the appropriate fees payable to the Board of Speech Pathology and Audiology. The fees are nonrefundable.

b. Verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification sent directly from the jurisdiction's board office if the verification provides:

(1) Licensee's name;

(2) Date of initial licensure;

(3) Current licensure status; and

(4) Any disciplinary action taken against the license.

c. Evidence of current ASHA certification or submission of documents required under 300.3(4) "b."

[ARC 1397C, IAB 4/2/14, effective 5/7/14; ARC 3591C, IAB 1/17/18, effective 2/21/18; ARC 4214C, IAB 1/2/19, effective 2/6/19]

#### **645—300.10(147) Licensure by reciprocal agreement.** Rescinded IAB 6/30/10, effective 8/4/10.

#### **645—300.11(147) License renewal.**

**300.11(1)** The biennial license renewal period for a license to practice speech pathology or audiology shall begin on January 1 of an even-numbered year and end on December 31 of the next odd-numbered

year. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

**300.11(2)** An individual who was issued an initial license within six months of the license renewal date will not be required to renew the license until the subsequent renewal date two years later.

**300.11(3)** A licensee seeking renewal shall:

*a.* Meet the continuing education requirements of rule 645—303.2(147) and the mandatory reporting requirements of subrule 300.11(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

*b.* Submit the completed renewal application and renewal fee before the license expiration date.

**300.11(4)** Mandatory reporter training requirements.

*a.* A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of training in child abuse identification and reporting as required by Iowa Code section 232.69(3) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 300.11(4) "e."

*b.* A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of training in dependent adult abuse identification and reporting as required by Iowa Code section 235B.16(5) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 300.11(4) "e."

*c.* The course(s) shall be the curriculum provided by the Iowa department of human services.

*d.* The licensee shall maintain written documentation for three years after mandatory training as identified in paragraphs 300.11(4) "a" and "b," including program date(s), content, duration, and proof of participation.

*e.* The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in rule 645—4.14(272C).

*f.* The board may select licensees for audit of compliance with the requirements in paragraphs 300.11(4) "a" to "e."

**300.11(5)** Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

**300.11(6)** A person licensed to practice as a speech pathologist or audiologist shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

**300.11(7)** Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule 5.20(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

**300.11(8)** Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a speech pathologist or audiologist in Iowa until the license is reactivated. A licensee who practices as a speech pathologist or audiologist in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 9947B, IAB 12/28/11, effective 2/1/12; ARC 3591C, IAB 1/17/18, effective 2/21/18; ARC 5161C, IAB 8/26/20, effective 10/1/20]

**645—300.12(17A,147,272C) Board meetings.**

**300.12(1)** Board meetings shall be governed in accordance with Iowa Code chapter 21, and board proceedings shall be conducted to ensure that all members have equal rights, privileges and obligations.

**300.12(2)** A majority of the members of the board shall constitute a quorum.

**300.12(3)** The board shall discuss all motions prior to a vote to allow for full and free discussion of every motion.

**300.12(4)** Official action, including filing of formal charges or imposition of discipline, requires a majority vote of members present.

[ARC 9947B, IAB 12/28/11, effective 2/1/12]

**645—300.13(272C) Lapsed licenses.** Rescinded IAB 9/14/05, effective 10/19/05.

**645—300.14(147) Duplicate certificate or wallet card.** Rescinded IAB 6/30/10, effective 8/4/10.

**645—300.15(147) Reissued certificate or wallet card.** Rescinded IAB 6/30/10, effective 8/4/10.

**645—300.16(17A,147,272C) License denial.** Rescinded IAB 6/30/10, effective 8/4/10.

**645—300.17(17A,147,272C) License reactivation.** To apply for reactivation of an inactive license, a licensee shall:

**300.17(1)** Submit a reactivation application on a form provided by the board.

**300.17(2)** Pay the reactivation fee that is due as specified in 645—subrule 5.20(4).

**300.17(3)** Provide verification of current competence to practice speech pathology and audiology by satisfying one of the following criteria:

*a.* If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 30 hours of continuing education within two years of application for reactivation.

*b.* If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 60 hours of continuing education within two years of application for reactivation; or

(3) Verification of passing the Praxis Examination in speech pathology or audiology within the last two years prior to application for reactivation.

[ARC 1397C, IAB 4/2/14, effective 5/7/14; ARC 3591C, IAB 1/17/18, effective 2/21/18]

**645—300.18(17A,147,272C) License reinstatement.** A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—300.17(17A,147,272C) prior to practicing speech pathology and audiology in this state.

[ARC 3591C, IAB 1/17/18, effective 2/21/18]

These rules are intended to implement Iowa Code chapters 17A, 147 and 272C.

[Filed 2/2/77, Notice 12/29/76—published 2/23/77, effective 3/30/77]

[Filed emergency 8/14/81—published 9/2/81, effective 8/14/81]

[Filed 8/28/81, Notice 3/4/81—published 9/16/81, effective 10/21/81]

[Filed 10/22/82, Notice 8/18/82—published 11/10/82, effective 12/17/82]

[Filed 1/14/83, Notice 11/24/82—published 2/2/83, effective 3/11/83]

[Filed 6/15/83, Notice 4/13/83—published 7/6/83, effective 8/11/83]

[Filed emergency 11/1/83 after Notice 9/14/83—published 11/23/83, effective 11/1/83]

[Filed 1/21/85, Notice 11/21/84—published 2/13/85, effective 3/20/85]

[Filed 6/18/86, Notice 4/9/86—published 7/16/86, effective 8/20/86]

[Filed 7/29/88, Notice 3/23/88—published 8/24/88, effective 9/28/88]

[Filed 7/29/88, Notice 5/4/88—published 8/24/88, effective 9/28/88]

[Filed 6/9/89, Notice 2/8/89—published 6/28/89, effective 8/2/89]

[Filed 4/12/91, Notice 1/9/91—published 5/1/91, effective 6/5/91]

[Filed 8/1/91, Notice 5/1/91—published 8/21/91, effective 9/25/91]

[Filed 11/22/91, Notice 8/21/91—published 12/11/91, effective 1/15/92]

[Filed 1/29/93, Notice 9/30/92—published 2/17/93, effective 4/1/93]

[Filed 2/23/94, Notice 12/8/93—published 3/16/94, effective 4/22/94]

[Filed 5/28/99, Notice 3/10/99—published 6/16/99, effective 7/21/99]

[Filed 2/15/00, Notice 12/15/99—published 3/8/00, effective 4/12/00]

[Filed 11/9/00, Notice 9/20/00—published 11/29/00, effective 1/3/01]

[Filed 8/30/01, Notice 5/30/01—published 9/19/01, effective 10/24/01]

[Filed 5/9/02, Notice 4/3/02—published 5/29/02, effective 7/3/02]

[Filed 8/14/03, Notice 5/28/03—published 9/3/03, effective 10/8/03]

[Filed 2/27/04, Notice 12/10/03—published 3/17/04, effective 4/21/04]

[Filed 8/22/05, Notice 6/8/05—published 9/14/05, effective 10/19/05]<sup>◇</sup>

[Filed 12/22/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]

[Filed ARC 8872B (Notice ARC 8639B, IAB 4/7/10), IAB 6/30/10, effective 8/4/10]

[Filed ARC 9947B (Notice ARC 9767B, IAB 10/5/11), IAB 12/28/11, effective 2/1/12]

[Filed ARC 1397C (Notice ARC 1314C, IAB 2/5/14), IAB 4/2/14, effective 5/7/14]

[Filed ARC 3591C (Notice ARC 3410C, IAB 10/25/17), IAB 1/17/18, effective 2/21/18]

[Filed ARC 4214C (Notice ARC 4035C, IAB 9/26/18), IAB 1/2/19, effective 2/6/19]

[Filed ARC 5161C (Notice ARC 4913C, IAB 2/12/20), IAB 8/26/20, effective 10/1/20]

<sup>◇</sup> Two or more ARCs



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[Prior to 11/19/97, see Labor Services Division[347]]

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CHAPTER 3  
POSTING, INSPECTIONS, CITATIONS AND PROPOSED PENALTIES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 3]

**875—3.1(88) Posting of notice; availability of the Act, regulations and applicable standards.**

**3.1(1)** Each employer shall post and keep posted a notice or notices informing employees of the protections and obligations provided for in the Act, and that for assistance and information, including copies of the Act and of specific safety and health standards, employees should contact the employer or the department of workforce development, division of labor services. The notice or notices shall be posted by the employer in each establishment in a conspicuous place or places where notices to employees are customarily posted. Each employer shall take steps to ensure that such notices are not altered, defaced or covered by other materials. The notice or notices will be furnished by the division of labor services.

Reproductions or facsimiles of the state poster shall constitute compliance with the posting requirements of Iowa Code section 88.6(3) “a” where such reproductions or facsimiles are at least 8½ inches by 14 inches, and the printing size is at least 10 point. Whenever the size of the poster increases, the size of the print shall also increase accordingly. The caption or heading on the poster shall be in large type, generally not less than 36 point.

**3.1(2)** “*Establishment*” means a single physical location where business is conducted or where services or industrial operations are performed. (For example: A factory, mill, store, hotel, restaurant, movie theatre, farm, ranch, bank, sales office, warehouse, central administrative office or governmental agency or subdivision thereof.) Where distinctly separate activities are performed at a single physical location (such as contract construction activities from the same physical location as a lumber yard), each activity shall be treated as a separate physical establishment, and a separate notice or notices shall be posted in each such establishment, to the extent that such notices have been furnished by the Occupational Safety and Health Administration, U.S. Department of Labor, or the division of labor services. Where employers are engaged in activities which are physically dispersed, such as agriculture, construction, transportation, communications and electric, gas and sanitary services, the notice or notices required by this rule shall be posted at the location to which employees report each day. Where employees do not usually work at, or report to, a single establishment, such as harbor workers, traveling salespersons, technicians, engineers, and similar personnel, such notice or notices shall be posted at the location from which the employees operate to carry out their activities. In all cases, such notice or notices shall be posted in accordance with the requirements of subrule 3.1(1).

**3.1(3)** Copies of the Act, all regulations published and all applicable safety and health rules are available from the division of labor services. If an employer has obtained copies of these materials from the division of labor services or the U.S. Department of Labor, the employer shall make them available upon request to any employee or authorized employee representative for review in the establishment where the employee is employed on the same day the request is made or at the earliest time mutually convenient to the employee or authorized employee representative and the employer.

**3.1(4)** Any employer failing to comply with the provisions of this rule shall be subject to citation and penalty in accordance with the provisions of Iowa Code section 88.14.

This rule is intended to implement Iowa Code section 88.6(3) “a.”

[ARC 3557C, IAB 1/3/18, effective 2/11/18]

**875—3.2(88) Objection to inspection.**

**3.2(1)** Upon a refusal to permit a compliance safety and health officer, in the exercise of official duties, to enter without delay and at reasonable times any place of employment or any place therein, to inspect, to review records or to question any employer, owner, operator, agent or employee, or to permit a representative of employees to accompany the compliance safety and health officer during the physical inspection of any workplace, the compliance safety and health officer shall terminate the inspection or confine the inspection to other areas, conditions, structures, machines, apparatus, devices, equipment, materials, records or interviews concerning which no objection is raised. The compliance safety and

health officer shall endeavor to ascertain the reason for such refusal and shall immediately report the refusal and the reason therefor to the labor commissioner or the commissioner's designee. The labor commissioner shall promptly take appropriate action, including compulsory process, if necessary.

**3.2(2)** Compulsory process shall be sought in advance of an attempted inspection or investigation if, in the judgment of the labor commissioner or a designee, circumstances exist which make such preinspection process desirable or necessary. Some examples of circumstances in which it may be desirable or necessary to seek compulsory process in advance of an attempt to inspect or investigate include (but are not limited to):

*a.* When the employer's past practice either implicitly or explicitly puts the commissioner on notice that a warrantless inspection will not be allowed, or

*b.* When an inspection includes the use of special equipment or when the presence of an expert or experts is needed in order to properly conduct the inspection, and procuring a warrant prior to an attempt to inspect would alleviate the difficulties or costs encountered in coordinating the availability of such equipment or expert.

**3.2(3)** For the purposes of this rule, the term "compulsory process" shall mean the institution of any appropriate action, including ex parte application for an inspection warrant or its equivalent. Ex parte inspection warrants shall be the preferred form of compulsory process in all circumstances where compulsory process is relied upon to seek entry to a workplace under this rule.

This rule is intended to implement Iowa Code section 88.6(1).

**875—3.3(88) Entry not a waiver.** Any permission to enter, inspect, review records or question any person shall not imply or be conditioned upon a waiver of any cause of action, citation or penalty under the Act. Compliance safety and health officers are not authorized to grant any such waiver.

This rule is intended to implement Iowa Code section 88.6(1).

**875—3.4(88) Advance notice of inspections.**

**3.4(1)** Advance notice of inspections may not be given, except in the following situations:

*a.* In cases of apparent imminent danger, to enable the employer to abate the danger as quickly as possible;

*b.* In circumstances where the inspection can most effectively be conducted after regular business hours or where special preparations are necessary for an inspection;

*c.* Where necessary to ensure the presence of representatives of the employer and employees or the appropriate personnel needed to aid in the inspection; and

*d.* In other circumstances where the labor commissioner or the commissioner's designee determines that the giving of advance notice would enhance the probability of an effective and thorough inspection.

**3.4(2)** In situations described in 3.4(1), advance notice of inspections may be given only if authorized by the labor commissioner or the commissioner's designee, except that in cases of apparent imminent danger, advance notice may be given by the compliance safety and health officer without such authorization if the labor commissioner or the commissioner's designee is not immediately available. When advance notice is given, it shall be the employer's responsibility promptly to notify the authorized representative of employees of the inspection, if the identity of the representative is known to the employer. Upon the request of the employer, the compliance safety and health officer will inform the authorized representative of employees of the inspection, provided that the employer furnishes the compliance safety and health officer with the identity of the representative and with other information as is necessary to enable the compliance safety and health officer promptly to inform the representative of the inspection. An employer who fails to comply with the obligation under this rule promptly to inform the authorized representative of employees of the inspection, or to furnish such information as is necessary to enable the compliance safety and health officer promptly to inform the representative of the inspection, may be subject to citation and penalty under Iowa Code section 88.14(3). Advance notice in any of the situations described in subrule 3.4(1) shall not be given more than 24 hours before

the inspection is scheduled to be conducted, except in apparent imminent danger situations and in other unusual circumstances.

This rule is intended to implement Iowa Code sections 88.6(1) and 88.14(6).

#### **875—3.5(88) Conduct of inspections.**

**3.5(1)** Inspections shall take place at the times and in the places of employment as the labor commissioner or the commissioner's designee may direct. At the beginning of an inspection, compliance safety and health officers shall present their credentials to the owner, operator or agent in charge at the establishment; explain the nature and purpose of the inspection; and indicate generally the scope of the inspection and the records they wish to review. However, such designation of records shall not preclude access to additional records.

**3.5(2)** Compliance safety and health officers shall have authority to take environmental samples and to take or obtain photographs related to the purpose of the inspection, employ other reasonable investigative techniques, and question privately any employer, owner, operator, agent or employee of the establishment. As used herein the term "employ other reasonable investigative techniques" includes, but is not limited to, the use of cameras, audio and videotaping equipment, devices to measure employee exposures and the attachment of personal sampling equipment such as dosimeters, pumps, badges and other similar devices to employees in order to monitor their exposures.

**3.5(3)** In taking photographs and samples, compliance safety and health officers shall take reasonable precautions to ensure that such actions with flash, spark-producing or other equipment would not be hazardous. Compliance safety and health officers shall comply with all employer safety and health rules and practices at the establishment being inspected, and they shall wear and use appropriate protective clothing and equipment.

**3.5(4)** The conduct of inspections shall be such as to preclude unreasonable disruption of the operations of the employer's establishment.

**3.5(5)** At the conclusion of the inspection, the compliance safety and health officer shall confer with the employer or representative and informally advise the employer or representative of any apparent safety or health violations disclosed by the inspection. During the conference, the employer shall be afforded an opportunity to bring to the attention of the compliance safety and health officer any pertinent information regarding conditions in the workplace.

**3.5(6)** Inspections shall be conducted in accordance with the requirements of this chapter.

This rule is intended to implement Iowa Code section 88.6(1).

[ARC 8522B, IAB 2/10/10, effective 3/17/10]

#### **875—3.6(88) Representatives of employers and employees.**

**3.6(1)** Compliance safety and health officers shall be in charge of inspections and questioning of persons. A representative of the employer and a representative authorized by employees shall be given an opportunity to accompany the compliance safety and health officer during the physical inspection of any workplace for the purpose of aiding the inspection. A compliance safety and health officer may permit additional employer representatives and additional representatives authorized by employees to accompany the compliance safety and health officer where the compliance safety and health officer determines that the additional representatives will further aid the inspection. A different employer and employee representative may accompany the compliance safety and health officer during each different phase of an inspection if this will not interfere with the conduct of the inspection.

**3.6(2)** Compliance safety and health officers shall have authority to resolve all disputes as to who is the representative authorized by the employer and employees for the purpose of this rule. If there is no authorized representative of employees, or if the compliance safety and health officer is unable to determine with reasonable certainty who is the representative, the compliance safety and health officer should consult with a reasonable number of employees concerning matters of safety and health in the workplace.

**3.6(3)** The representative(s) authorized by employees shall be an employee(s) of the employer. However, if in the judgment of the compliance safety and health officer, good cause has been shown

why accompaniment by a third party who is not an employee of the employer (such as an industrial hygienist or a safety engineer) is reasonably necessary to the conduct of an effective and thorough physical inspection of the workplace, the third party may accompany the compliance safety and health officer during the inspection.

**3.6(4)** Compliance safety and health officers are authorized to deny the right of accompaniment under this rule to any person whose conduct interferes with a fair and orderly inspection.

This rule is intended to implement Iowa Code sections 88.6(1) and 88.6(4).

**875—3.7(88) Complaints by employees.**

**3.7(1)** Any employee or representative of employees who believes that a violation of the Act exists in any workplace where the employee is employed may request an inspection of the workplace by giving notice of the alleged violation to the commissioner or a designee. Any such notice shall be reduced to writing, shall set forth with reasonable particularity the grounds for the notice, and shall be signed by the employee or representative of employees. A copy shall be provided the employer or agent by the commissioner's designee no later than at the time of inspection, except that, upon the request of the person giving the notice, the identity and the identities of individual employees referred to therein shall not appear in the copy or on any record published, released, or made available by the division of labor services.

**3.7(2)** If upon receipt of notification the commissioner or a designee determines that the complaint meets the requirements set forth in subrule 3.7(1), and that there are reasonable grounds to believe that the alleged violation exists, an inspection shall be made as soon as practicable, to determine if the alleged violation exists. Inspections under this rule shall not be limited to matters referred to in the complaint.

**3.7(3)** During any inspection of a workplace, any employee or representative of employees employed in the workplace may notify the compliance safety and health officer of any violation of the Act which they have reason to believe exists in the workplace.

**875—3.8(88) Trade or governmental secrets.**

**3.8(1)** At the commencement of an inspection, the employer may identify areas in the establishment which contain or which might reveal trade or governmental secrets. If the compliance safety and health officer has no clear reason to question such identification, information obtained in such areas, including all negatives and prints of photographs and environmental samples, shall be labeled "confidential-trade/governmental secrets" and shall not be disclosed except in accordance with the provisions of Iowa Code section 88.12.

**3.8(2)** Upon the request of an employer, any authorized representative of employees in an area containing trade or governmental secrets shall be an employee in that area or an employee authorized by the employer to enter that area. Where there is no representative or employee, the compliance safety and health officer shall consult with a reasonable number of employees who work in that area concerning matters of safety and health.

This rule is intended to implement Iowa Code sections 88.6(1) and 88.12.

**875—3.9(88) Imminent danger.** Whenever and as soon as a compliance safety and health officer concludes on the basis of an inspection that conditions or practices exist in any place of employment which could reasonably be expected to cause death or serious physical harm immediately or before the imminence of such danger can be eliminated through the enforcement procedures otherwise provided by the Act, the affected employees and employers shall be notified as provided in Iowa Code section 88.11(3). Appropriate citations and notices of proposed penalties may be issued with respect to an imminent danger even though, after being informed of the danger by the compliance safety and health officer, the employer immediately eliminates the imminence of the danger and initiates steps to abate the danger.

**875—3.10(88) Consultation with employees.** Compliance safety and health officers may consult with employees concerning matters of occupational safety and health to the extent that they deem necessary for

the conduct of an effective and thorough inspection. During the course of an inspection, any employee shall be afforded an opportunity to bring any violation of the Act which the employee has reason to believe exists in the workplace to the attention of the compliance safety and health officer.

This rule is intended to implement Iowa Code sections 88.6(1) and 88.6(4).

### **875—3.11(88) Citations.**

**3.11(1)** The civil penalties proposed by the labor commissioner on or after October 3, 2020, are as follows:

*a. Willful violation.* The penalty for each willful violation under Iowa Code section 88.14(1) shall not be less than \$9,639 and shall not exceed \$134,937.

*b. Repeated violation.* The penalty for each repeated violation under Iowa Code section 88.14(1) shall not exceed \$134,937.

*c. Serious violation.* The penalty for each serious violation under Iowa Code section 88.14(2) shall not exceed \$13,494.

*d. Other-than-serious violation.* The penalty for each other-than-serious violation under Iowa Code section 88.14(3) shall not exceed \$13,494.

*e. Failure to correct violation.* The penalty for failure to correct a violation under Iowa Code section 88.14(4) shall not exceed \$13,494 per day.

*f. Posting, reporting, or record-keeping violation.* The penalty for each posting, reporting, or record-keeping violation under Iowa Code section 88.14(9) shall not exceed \$13,494.

**3.11(2)** Upon receipt of any citation under the Act, the employer shall immediately post the citation or a copy thereof, unedited, at or near each place an alleged violation referred to in the citation occurred, except as provided in this rule. Where, because of the nature of the employer's operations, it is not practicable to post the citation at or near each place of alleged violation, the citation shall be posted, unedited, in a prominent place where it will be readily observable by all affected employees. For example, where employers are engaged in activities which are physically dispersed, the citation may be posted at the location to which employees report each day. Where employees do not primarily work at or report to a single location, the citation may be posted at the location from which the employees operate to carry out their activities. The employer shall take steps to ensure that the citation is not altered, defaced or covered by other material. Notices of de minimis violations need not be posted.

**3.11(3)** Each citation or a copy thereof shall remain posted until the violation has been abated, or for three working days, whichever is later. The filing by the employer of a notice of intention to contest shall not affect the posting responsibility under this rule unless and until the employment appeal board issues a final order vacating the citation.

**3.11(4)** An employer to whom a citation has been issued may post a notice in the same location where such citation is posted indicating that the citation is being contested before the employment appeal board and the notice may explain the reasons for the contest. The employer may also indicate that specified steps have been taken to abate the violation.

**3.11(5)** Any employer failing to comply with the provisions of subrules 3.11(2) and 3.11(3) shall be subject to citation and penalty in accordance with the provisions of Iowa Code section 88.14.

**3.11(6)** Any employer to whom a citation and notification of penalty have been issued may, under Iowa Code section 88.8, notify the commissioner of the employer's intention to contest the citation or notification of penalty. The notice of contest shall be in writing. The notice of contest shall be received by the division of labor services or postmarked no later than 15 working days after the receipt by the employer of the citation and notification of penalty. The notice of contest may be provided to the division of labor services by mail, personal delivery or facsimile transmission.

This rule is intended to implement Iowa Code chapter 88.

[ARC 3557C, IAB 1/3/18, effective 2/11/18; ARC 3810C, IAB 5/23/18, effective 6/30/18; ARC 4412C, IAB 4/24/19, effective 5/29/19; ARC 4640C, IAB 8/28/19, effective 10/2/19; ARC 5157C, IAB 8/26/20, effective 10/3/20]

**875—3.12(88) Informal conferences.** At the request of an affected employer, employee, or representative of employees, the labor commissioner or the commissioner's designee may hold an informal conference for the purpose of discussing any issues raised by an inspection, citation, notice of

proposed penalty, or notice of intention to contest. The settlement of any issue at the conference shall be subject to the rules of procedure prescribed by the employment appeal board. If the conference is requested by the employer, an affected employee or the employee's representative shall be afforded an opportunity to participate, at the discretion of the labor commissioner or the commissioner's designee. If the conference is requested by an employee or representative of employees, the employer shall be afforded an opportunity to participate, at the discretion of the labor commissioner or the commissioner's designee. Any party may be represented by counsel at the conference. No conference or request for a conference shall operate as a stay of any 15-working-day period for filing a notice of intention to contest.

This rule is intended to implement Iowa Code sections 17A.3(1) "b" and 17A.10.

**875—3.13(88) Petitions for modification of abatement date.**

**3.13(1)** An employer may file a petition for modification of abatement date when the employer has made a good faith effort to comply with the abatement requirements of a citation, but such abatement has not been completed because of factors beyond its reasonable control.

**3.13(2)** A petition for modification of abatement date shall be in writing and shall include the following information:

- a.* All steps taken by the employer, and the dates of the action, in an effort to achieve compliance during the prescribed abatement period.
- b.* The specific additional abatement time necessary in order to achieve compliance.
- c.* The reasons the additional time is necessary, including the unavailability of professional or technical personnel or of materials and equipment, or because necessary construction or alteration of facilities cannot be completed by the original abatement date.
- d.* All available interim steps being taken to safeguard the employees against the cited hazard during the abatement period.
- e.* A certification that a copy of the petition and notice informing affected employees of their rights to party status has been posted and, if appropriate, served on the authorized representative of affected employees, in accordance with 3.13(3) "a" and a certification of the date upon which the posting and service was made. A notice in the following form shall be deemed to comply with this paragraph:

(Name of employer)

Your employer has been cited by the commissioner of labor for violation of the Iowa Occupational Safety and Health Act and has requested additional time to correct one or more of the violations. Affected employees are entitled to participate as parties under terms and conditions established by the Iowa employment appeal board in its rules of procedure. Affected employees or their representatives desiring to participate must file a written objection to the employer's petition with the commissioner of labor. Failure to file the objection within ten working days of the first posting of the accompanying petition and this notice shall constitute a waiver of any further right to object to the petition or to participate in any proceedings related thereto. Objections shall be sent to the commissioner's designee: Iowa OSHA, Division of Labor Services, 1000 East Grand Avenue, Des Moines, Iowa 50319. All papers relevant to this matter may be inspected at: (place reasonably convenient to employees, preferably at or near workplace).

**3.13(3)** A petition for modification of abatement date shall be filed with the labor commissioner or the commissioner's designee no later than the close of the next working day following the date on which abatement was originally required. A later-filed petition shall be accompanied by the employer's statement of exceptional circumstances explaining the delay.

*a.* A copy of the petition and a notice of employee rights complying with 3.13(2) "e" shall be posted in a conspicuous place where all affected employees will have notice thereof or near the location where the violation occurred. The petition and notice of employee rights shall remain posted for a period of ten working days. Where affected employees are represented by an authorized representative, the representative shall be served with a copy of the petition and notice of employee rights.

*b.* Affected employees or their representatives may file an objection in writing to a petition with the labor commissioner or the commissioner's designee. Failure to file the objection within ten working

days of the date of posting of the petition and notice of employee rights or of service upon an authorized representative shall constitute a waiver of any further right to object to the petition.

c. The labor commissioner or the commissioner's designee shall have the authority to approve any filed petition for modification of abatement date. Uncontested petitions shall become final orders pursuant to Iowa Code section 88.8.

d. The labor commissioner or the commissioner's designee shall not exercise approval power until the expiration of 15 working days from the date the petition and notice of employee rights were posted or served by the employer.

**3.13(4)** Where any petition is objected to by the labor commissioner or the commissioner's designee or affected employees, the petition, citation, and any objections shall be forwarded to the employment appeal board within 3 working days after the expiration of the 15-day period set out in subrule 3.13(3) "d."

This rule is intended to implement Iowa Code section 88.8.  
[ARC 3557C, IAB 1/3/18, effective 2/11/18]

**875—3.14 to 3.18** Reserved.

**875—3.19(88) Abatement verification.**

**3.19(1) Scope and application.** This rule applies to employers who receive a citation for a violation of the Iowa Occupational Safety and Health Act.

**3.19(2) Definitions.**

"*Abatement*" means action by an employer to comply with a cited standard or regulation or to eliminate a recognized hazard identified by OSHA during an inspection.

"*Abatement date*" means:

1. For an uncontested citation item, the later of:
  - The date in the citation for abatement of the violation;
  - The date approved by OSHA or established in litigation as a result of a petition for modification of the abatement date (PMA); or
  - The date established in a citation by an informal settlement agreement.
2. For a contested citation item for which the employment appeal board has issued a final order affirming the violation, the later of:
  - The date identified in the final order for abatement; or
  - The date computed by adding the period allowed in the citation for abatement to the final order date;
  - The date established by a formal settlement agreement.

"*Affected employees*" means those employees who are exposed to the hazard(s) identified as a violation(s) in a citation.

"*Final order date*" means:

1. For an uncontested citation item, the fifteenth working day after the employer's receipt of the citation;
2. For a contested citation item:
  - The thirtieth day after the date on which a final order was entered by the employment appeal board or
  - The date on which a court issues a decision affirming the violation in a case in which a final order of employment appeal board has been stayed.

"*Movable equipment*" means a hand-held or non-hand-held machine or device, powered or unpowered, that is used to do work and is moved within or between work sites.

**3.19(3) Abatement certification.**

a. Within ten calendar days after the abatement date, the employer must certify to the division that each cited violation has been abated, except as provided in paragraph "b" of this subrule.

b. The employer is not required to certify abatement if the compliance safety and health officer during the on-site portion of the inspection:

- (1) Observes, within 24 hours after a violation is identified, that abatement has occurred; and
- (2) Notes in the citation that abatement has occurred.

c. The employer's certification that abatement is complete must include, for each cited violation, in addition to the information required in 3.19(8), the date and method of abatement and a statement that affected employees and their representatives have been informed of the abatement.

**3.19(4) Abatement documentation.**

a. The employer must submit to the division, along with the information on abatement certification required by subrule 3.19(3), paragraph "c," documents demonstrating that abatement is complete for each willful or repeat violation and for any serious violation for which the division indicates in the citation that the abatement documentation is required.

b. Documents demonstrating that abatement is complete may include, but are not limited to, evidence of the purchase or repair of equipment, photographic or video evidence of abatement, or other written records.

**3.19(5) Abatement plans.**

a. The division may require an employer to submit an abatement plan for each cited violation (except an other-than-serious violation) when the time permitted for abatement is more than 90 calendar days. If an abatement plan is required, the citation must so indicate.

b. The employer must submit an abatement plan for each cited violation within 25 calendar days from the final order date when the citation indicates that such a plan is required. The abatement plan must identify the violation and the steps to be taken to achieve abatement, including a schedule for completing abatement and, where necessary, how employees will be protected from exposure to the violative condition in the interim until abatement is complete.

**3.19(6) Progress reports.**

a. An employer who is required to submit an abatement plan may also be required to submit periodic progress reports for each cited violation. The citation must indicate:

- (1) That periodic progress reports are required and the citation items for which they are required;
- (2) The date on which an initial progress report must be submitted, which may be no sooner than 30 calendar days after submission of an abatement plan;
- (3) Whether additional progress reports are required; and
- (4) The date(s) on which additional progress reports must be submitted.

b. For each violation, the progress report must identify, in a single sentence if possible, the action taken to achieve abatement and the date the action was taken.

**3.19(7) Employee notification.**

a. The employer must inform affected employees and their representative(s) about abatement activities covered by this rule by posting a copy of each document submitted to the division or a summary of the document near the place where the violation occurred.

b. Where posting does not effectively inform employees and their representatives about abatement activities (for example, for employers who have mobile work operations), the employer shall:

- (1) Post each document or a summary of the document in a location where it will be readily observable by affected employees and their representatives; or
- (2) Take other steps to communicate fully to affected employees and their representatives about abatement activities.
- (3) The employer must inform employees and their representatives of their right to examine and copy all abatement documents submitted to the division.

c. An employee or an employee representative shall submit a request to examine and copy abatement documents within three working days of receiving notice that the documents have been submitted. The employer shall comply with an employee's or employee representative's request to examine and copy abatement documents within five working days of receiving the request.

d. The employer must ensure that notice to employees and employee representatives is provided at the same time or before the information is provided to the division and that abatement documents are:

- (1) Not altered, defaced, or covered by other material; and



(2) Remain posted for three working days after submission to the division.

**3.19(8) *Transmitting abatement documents.***

a. The employer must include, in each submission required by this rule, the following information:

1. The employer's name and address;
2. The inspection number to which the submission relates;
3. The citation and item numbers to which the submission relates;
4. A statement that the information submitted is accurate; and
5. The signature of the employer or the employer's authorized representative.

b. The date of postmark is the date of submission for mailed documents. For documents transmitted by other means, the date the division receives the document is the date of submission.

**3.19(9) *Movable equipment.***

a. For serious, repeat, and willful violations involving movable equipment, the employer must attach a warning tag or a copy of the citation to the operating controls or to the cited component of equipment that is moved within the work site or between work sites. Attaching a copy of the citation to the equipment is deemed to meet the tagging requirement of this paragraph as well as the posting requirement of rule 875—3.11(88).

b. The employer must use a warning tag that properly warns employees about the nature of the violation involving the equipment and identifies the location of the citation issued. A sample tag is available at [osha.gov](https://www.osha.gov) as Appendix C to 29 CFR 1903.19.

c. If the violation has not already been abated, a warning tag or copy of the citation must be attached to the equipment:

- (1) For hand-held equipment, immediately after the employer receives the citation; or
- (2) For non-hand-held equipment, prior to moving the equipment within or between work sites.

d. For the construction industry, a tag that is designed and used in accordance with 29 CFR 1926.20(b)(3) and 29 CFR 1926.200(h) is deemed by OSHA to meet the requirements of this rule when the information required by subrule 3.19(9), paragraph "b," is included on the tag.

e. The employer must ensure that the tag or copy of the citation attached to movable equipment is not altered, defaced, or covered by other material.

f. The employer must ensure that the tag or copy of the citation attached to movable equipment remains attached until:

- (1) The violation has been abated and all abatement verification documents required by this regulation have been submitted to the division;
- (2) The cited equipment has been permanently removed from service or is no longer within the employer's control; or
- (3) The appeal board issues a final order vacating the citation.

[ARC 3557C, IAB 1/3/18, effective 2/11/18]

**875—3.20(88) Policy regarding employee rescue activities.**

**3.20(1)** The labor commissioner or the commissioner's designee shall review the inspection report of the compliance safety and health officer. If, on the basis of the report, the labor commissioner or the commissioner's designee believes that the employer has violated a requirement of Iowa Code section 88.4 or any rule, the commissioner or the commissioner's designee shall issue to the employer either a citation or a notice of de minimis violations which has no direct or immediate relationship to safety or health. An appropriate citation or notice of de minimis violations shall be issued even though after being informed of an alleged violation by the compliance safety and health officer, the employer immediately abates, or initiates steps to abate, such alleged violation. Any citation or notice of de minimis violations shall be issued with reasonable promptness after termination of the inspection. No citation may be issued under this rule after the expiration of six months following the occurrence of any alleged violation.

**3.20(2)** Any citation shall describe with particularity the nature of the alleged violation, including a reference to Iowa Code chapter 88, or rule alleged to have been violated. Any citation shall also fix a reasonable time or times for the abatement of the alleged violation.

**3.20(3)** If a citation or notice of de minimis violations is issued for a violation alleged in a request for inspection under subrule 3.7(1) or a notification of violation under subrule 3.7(3), a copy of the citation or notice of de minimis violations shall also be sent to the employee or representative of employees who made such request or notification.

**3.20(4)** Every citation shall state that the issuance of a citation does not constitute a finding that a violation has occurred unless there is a failure to contest as provided for in Iowa Code chapter 88 or, if contested, unless the citation is affirmed by the appeal board.

**3.20(5)** No citation may be issued to an employer because of a rescue activity undertaken by an employee of that employer with respect to an individual in imminent danger unless:

*a.* The employee is designated or assigned by the employer to have responsibility to perform or assist in rescue operations, and the employer fails to provide protection of the safety and health of the employee, including failing to provide appropriate training and rescue equipment; or

*b.* The employee is directed by the employer to perform rescue activities in the course of carrying out the employee's job duties, and the employer fails to provide protection of the safety and health of such employee, including failing to provide appropriate training and rescue equipment; or

*c.* The employee is employed in a workplace that requires the employee to carry out duties that are directly related to a workplace operation where the likelihood of life-threatening accidents is foreseeable, such as a workplace operation where employees are located in confined spaces or trenches, handle hazardous waste, respond to emergency situations, perform excavations, or perform construction over water; and such employee has not been designated or assigned to perform or assist in rescue operations and voluntarily elects to rescue such an individual. Additionally, the employer has failed to instruct employees not designated or assigned to perform or assist in rescue operations of the arrangements for rescue, not to attempt rescue, and of the hazards of attempting rescue without adequate training or equipment.

**3.20(6)** For purposes of this policy, the term "imminent danger" means the existence of any condition or practice that could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated.

**875—3.21** Reserved.

**875—3.22(88,89B) Additional hazard communication training requirements.**

**3.22(1)** *Training format.* The employer may present the training program to the employee in any format; however, the employer shall preserve a written summary and synopsis of the training, a cassette tape recording of an oral presentation, or a videotape recording of an audio-video presentation of the training relied upon by the employer for compliance with 29 CFR 1910.1200(h), and shall allow employees and their designated representatives access to the written synopsis, tape recording, or videotape recording.

**3.22(2)** *Review by the division.* The training program shall be available for review and approval upon inspection by the division. Upon request by the commissioner, the employer shall make available the written synopsis, cassette tape recording, or videotape recording used or prepared by the employer. The commissioner may conduct an inspection to review an actual training program or review the employer's records of a training program.

**875—3.23(88) Definitions.** The definitions and interpretations contained in Iowa Code section 88.3 shall be applicable to the terms when used in this chapter. As used in this chapter unless the context clearly requires otherwise:

"*Act*" means the Iowa Occupational Safety and Health Act of 1972, Iowa Code chapter 88.

"*Compliance safety and health officer*" means a person authorized by the labor commissioner of the department of workforce development, division of labor services, to conduct inspections.

"*Division*" means the Iowa division of labor of the department of workforce development.

"*Inspection*" means any inspection of an employer's factory, plant, establishment, construction site or other area, workplace or environment where work is preformed by an employee of an employer, and

includes any inspection conducted pursuant to a filed complaint, and any follow-up inspection, accident investigation or other inspections conducted under the Act.

*“Working days”* means Mondays through Fridays but shall not include Saturdays, Sundays or federal or state holidays. In computing 15 working days, the day of receipt of any notice shall not be included, and the last day of the 15 working days shall be included.

This rule is intended to implement Iowa Code section 88.6.

**875—3.24(88) Occupational safety and health bureau forms.** Rescinded **ARC 3557C**, IAB 1/3/18, effective 2/11/18.

These rules are intended to implement Iowa Code chapters 17A and 88.

[Filed August 29, 1972]

[Filed 12/15/75, Notice 10/6/75—published 12/29/75, effective 2/4/76]

[Filed emergency 11/20/79—published 12/12/79, effective 11/20/79]

[Filed 1/31/80, Notice 12/26/79—published 2/20/80, effective 3/28/80]

[Filed 7/1/83, Notice 5/11/83—published 7/20/83, effective 9/1/83]

[Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]

[Filed emergency 4/17/87—published 5/6/87, effective 4/17/87]

[Filed 4/17/87, Notice 9/24/86—published 5/6/87, effective 6/10/87]

[Filed 10/10/91, Notice 6/12/91—published 10/30/91, effective 12/6/91]

[Filed 1/26/99, Notice 12/16/98—published 2/24/99, effective 3/31/99]

[Filed ARC 8522B (Notice ARC 8378B, IAB 12/16/09), IAB 2/10/10, effective 3/17/10]

[Filed ARC 3557C (Notice ARC 3415C, IAB 10/25/17), IAB 1/3/18, effective 2/11/18]

[Filed ARC 3810C (Notice ARC 3702C, IAB 3/28/18), IAB 5/23/18, effective 6/30/18]

[Filed ARC 4412C (Notice ARC 4318C, IAB 2/27/19), IAB 4/24/19, effective 5/29/19]

[Filed ARC 4640C (Notice ARC 4520C, IAB 7/3/19), IAB 8/28/19, effective 10/2/19]

[Filed ARC 5157C (Notice ARC 4938C, IAB 2/26/20), IAB 8/26/20, effective 10/3/20]



CHAPTER 4  
RECORDING AND REPORTING OCCUPATIONAL INJURIES AND ILLNESSES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 4]

**875—4.1(88) Purpose and scope.** These rules provide for record keeping and reporting by employers covered under Iowa Code chapter 88 as necessary or appropriate for enforcement of the Act, for developing information regarding the causes and prevention of occupational accidents and illnesses, and for maintaining a program of collection, compilation and analysis of occupational safety and health statistics. This chapter applies to public and private employers, and the use of the word “company” or “companies” in the standard adopted by reference herein shall not limit the scope or application of this chapter to private employers.

**875—4.2(88) First reports of injury.** All employers shall report to the Iowa division of workers’ compensation any occupational injury or illness which temporarily disables an employee for more than three days or which results in permanent total disability, permanent partial disability or death. This report shall be made within four days from such event when such injury or illness is alleged by the employee to have been sustained in the course of the employee’s employment. First reports of injury are to be filed in the form and manner required by the division of workers’ compensation. A report to the division of workers’ compensation is considered to be a report to the division of labor services. The division of workers’ compensation shall forward all reports to the division of labor services. This rule does not excuse employers from making reports required by rule 875—4.3(88).

[ARC 1782C, IAB 12/10/14, effective 1/14/15]

**875—4.3(88) Recording and reporting regulations.** Except as noted in this rule, the Federal Occupational Safety and Health Administration regulations at 29 CFR 1904.0 through 1904.46 as published at 66 Fed. Reg. 6122 to 6135 (January 19, 2001) are adopted.

**4.3(1)** The following amendments to 29 CFR 1904.0 through 1904.46 are adopted:

- a. 66 Fed. Reg. 52031-52034 (October 12, 2001)
- b. 67 Fed. Reg. 44047 (July 1, 2002)
- c. 67 Fed. Reg. 77170 (December 17, 2002)
- d. 68 Fed. Reg. 38606 (June 30, 2003)
- e. 79 Fed. Reg. 56186 (September 18, 2014)
- f. 81 Fed. Reg. 29691 (May 12, 2016)
- g. 81 Fed. Reg. 31854 (May 20, 2016)
- h. 84 Fed. Reg. 405 (January 25, 2019)
- i. 84 Fed. Reg. 21457 (May 14, 2019)
- j. 85 Fed. Reg. 8731 (February 18, 2020)

**4.3(2)** In addition to the reporting methods set forth in 29 CFR 1904.39(a), employers may make reports required by 29 CFR 1904.39 using at least one of the following methods:

- a. Completing the incident report form available at [www.iowaosha.gov](http://www.iowaosha.gov) and faxing the completed form to (515)242-5076 or sending the completed form to [osha@iwd.iowa.gov](mailto:osha@iwd.iowa.gov);
- b. Calling (877)242-6742; or
- c. Visiting 150 Des Moines Street, Des Moines, Iowa.

[ARC 1782C, IAB 12/10/14, effective 1/14/15; ARC 2688C, IAB 8/31/16, effective 11/1/16; ARC 4412C, IAB 4/24/19, effective 5/29/19; ARC 4640C, IAB 8/28/19, effective 10/2/19; ARC 5022C, IAB 4/8/20, effective 5/13/20; ARC 5158C, IAB 8/26/20, effective 9/30/20]

**875—4.4(88) Supplementary record.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.5(88) Annual summary.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.6(88) Retention of records.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.7(88) Access to records.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.8(88) Reporting of fatality or multiple hospitalization incidents.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.9(88) Falsification or failure to keep records or reports.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.10(88) Change of ownership.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.11** Reserved.

**875—4.12(88) Petitions for record-keeping exceptions.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.13(88) Description of statistical program.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.14(88) Duties.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.15(88) Employees not in fixed establishments.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.16(88) Small employers.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.17(88) Bureau of inspections and reporting, research and statistical section forms.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.18(88) Definitions.** Rescinded IAB 1/23/02, effective 1/1/02.

**875—4.19(88) Establishments classified in Standard Industrial Classification Codes (SIC) 52-89 (except 52-54, 70, 75, 76, 79 and 80).** Rescinded IAB 1/23/02, effective 1/1/02.

These rules are intended to implement Iowa Code chapter 88.

[Filed July 13, 1972; amended August 29, 1972, December 1, 1972, April 2, 1973,  
February 28, 1975]

[Filed 12/15/75, Notice 10/6/75—published 12/29/75, effective 2/4/76]

[Filed 11/18/77, Notice 10/5/77—published 12/14/77, effective 1/20/78]

[Filed 3/15/78, Notice 2/8/78—published 4/5/78, effective 5/15/78]

[Filed 11/2/78, Notice 9/20/78—published 11/15/78, effective 12/22/78]

[Filed emergency 11/8/79—published 11/28/79, effective 1/1/80]

[Filed emergency 11/20/79—published 12/12/79, effective 11/20/79]

[Filed emergency 12/5/79—published 12/26/79, effective 12/5/79]

[Filed emergency 12/5/79—published 12/26/79, effective 1/1/80]

[Filed 10/3/80, Notice 7/9/80—published 10/29/80, effective 12/3/80]

[Filed 7/1/83, Notice 5/11/83—published 7/20/83, effective 9/1/83]

[Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]

[Filed 4/17/87, Notice 9/24/86—published 5/6/87, effective 6/10/87]

[Filed emergency 10/6/94 after Notice 7/6/94—published 10/26/94, effective 10/26/94]

[Filed 1/21/00, Notice 8/25/99—published 2/9/00, effective 3/15/00]

[Filed emergency 12/19/01 after Notice 11/14/01—published 1/23/02, effective 1/1/02]

[Filed emergency 11/22/02—published 12/11/02, effective 1/1/03]

[Filed 3/28/03, Notice 2/19/03—published 4/16/03, effective 5/21/03]

[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 8/4/04]

[Filed ARC 1782C (Notice ARC 1677C, IAB 10/15/14), IAB 12/10/14, effective 1/14/15]

[Filed ARC 2688C (Notice ARC 2615C, IAB 7/6/16), IAB 8/31/16, effective 11/1/16]

[Filed ARC 4412C (Notice ARC 4318C, IAB 2/27/19), IAB 4/24/19, effective 5/29/19]

[Filed ARC 4640C (Notice ARC 4520C, IAB 7/3/19), IAB 8/28/19, effective 10/2/19]

[Filed ARC 5022C (Notice ARC 4894C, IAB 2/12/20), IAB 4/8/20, effective 5/13/20]

[Filed ARC 5158C (Notice ARC 4996C, IAB 3/25/20), IAB 8/26/20, effective 9/30/20]





CHAPTER 10  
GENERAL INDUSTRY SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 10]

**875—10.1(88) Definitions.** As used in these rules, unless the context clearly requires otherwise:

“*Part*” means 875—Chapter 10, Iowa Administrative Code.

“*Standard*” means a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.

**875—10.2(88) Applicability of standards.**

**10.2(1)** None of the standards in this chapter shall apply to working conditions of employees with respect to which federal agencies other than the United States Department of Labor, exercise statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health.

**10.2(2)** If a particular standard is specifically applicable to a condition, practice, means, method, operation, or process, it shall prevail over any different general standard which might otherwise be applicable to the same condition, practice, means, method, operation, or process.

**10.2(3)** However, any standard shall apply according to its terms to any employment and place of employment in any industry, even though particular standards are also prescribed for the industry, as in 1910.12, 1910.261, 1910.262, 1910.263, 1910.264, 1910.265, 1910.266, 1910.267, and 1910.268 of 29 CFR 1910, to the extent that none of such particular standards applies.

**10.2(4)** In the event a standard protects on its face a class of persons larger than employees, the standard shall be applicable under this part only to employees and their employment and places of employment.

**10.2(5)** An employer who is in compliance with any standard in this part shall be deemed to be in compliance with the requirement of Iowa Code section 88.4, but only to the extent of the condition, practice, means, method, operation or process covered by the standard.

**875—10.3(88) Incorporation by reference.** The standards of agencies of the U.S. Government, and organizations which are not agencies of the U.S. Government which are incorporated by reference in this chapter have the same force and effect as other standards in this chapter. Only mandatory provisions (i.e., provisions containing the word “shall” or other mandatory language) of standards incorporated by reference are adopted under the Act.

**875—10.4(88) Exception for hexavalent chromium exposure in metal and surface finishing job shops.** Prior to December 31, 2008, for employers that comply with the requirements of this rule, the labor commissioner shall enforce respiratory protection provisions only with respect to employees who fall into one of the six categories outlined in Paragraph 4, Appendix A, 29 CFR 1910.1026, except that the phrase “Exhibit B to this Agreement” shall refer to Exhibit B, Appendix A, 29 CFR 1910.1026. This exception is limited to the narrow circumstances outlined below and shall expire on May 31, 2010.

**10.4(1) Eligibility.** An employer’s facility is eligible for this exception if the employer is a member of the Surface Finishing Industry Council or the facility is a surface-finishing or metal-finishing job shop that sells plating or anodizing services to other companies.

**10.4(2) Participation.** To be covered by this exception, eligible employers must complete and submit a Declaration of Participation via mail to the Labor Commissioner, 1000 East Grand Avenue, Des Moines, Iowa 50319, or via facsimile to (515)281-7995. Declarations of Participation must be postmarked or received on or before April 7, 2007. Each declaration shall apply only to one facility. Declaration of Participation forms are available at [www.iowaworkforce.org/labor/iosh/index.html](http://www.iowaworkforce.org/labor/iosh/index.html) or by calling (515)242-5870.

**10.4(3) Applicability.** This exception applies only to surface- and metal-finishing operations within covered facilities.

**10.4(4) Feasible engineering controls.** Participating employers must implement feasible engineering controls necessary to reduce hexavalent chromium levels at their facilities to or below five micrograms per cubic meter of air calculated as an eight-hour, time-weighted average by December 31, 2008. In fulfilling this obligation, participating employers may select from the engineering and work practice controls listed in Exhibit A, Appendix A, 29 CFR 1910.1026, or may adopt other controls.

**10.4(5) Employee training.** Participating employers shall train their employees in accordance with the provisions of 29 CFR 1910.1026(l)(2). Using language the employees can understand, participating employers will also train their employees on the provisions of this exception no later than June 7, 2007.

**10.4(6) Compliance and monitoring.** Participating employers shall comply with the requirements set forth in Paragraphs 3 and 4, Appendix A, 29 CFR 1910.1026, except that as used in Appendix A:

- a. The acronym “OSHA” shall refer to the labor commissioner;
- b. The word “Company” shall refer to employers participating in this exception;
- c. The word “Agreement” shall refer to this rule; and
- d. The phrase “Exhibit B to this Agreement” shall refer to Exhibit B, Appendix A, 29 CFR 1910.1026.

**875—10.5 and 10.6** Reserved.

**875—10.7(88) Definitions and requirements for a nationally recognized testing laboratory.** The federal regulations adopted at 29 CFR, Chapter XVII, Part 1910, regulation 1910.7 and Appendix A, as published at 53 Fed. Reg. 12120 (April 12, 1988) and amended at 53 Fed. Reg. 16838 (May 11, 1988), 54 Fed. Reg. 24333 (June 7, 1989) and 65 Fed. Reg. 46818 (July 31, 2000) are adopted by reference.

**875—10.8 to 10.11** Reserved.

**875—10.12(88) Construction work.**

**10.12(1) Standards.** The standards prescribed in 875—Chapter 26 are adopted as occupational safety and health standards and shall apply, according to the provisions thereof, to every employment and place of employment of every employee engaged in construction work. Each employer shall protect the employment and places of employment of each employee engaged in construction work by complying with the provisions of 875—Chapter 26.

**10.12(2) Definition.** For the purpose of this rule, “*construction work*” means work for construction, alteration, or repair including painting and redecorating, and where applicable, the erection of new electrical transmission and distribution lines and equipment, and the alteration, conversion, and improvement of the existing transmission and distribution lines and equipment. This incorporation by reference of 875—Chapter 26 (Part 1926) is not intended to include references to interpretative rules having relevance to the application of the construction safety Act, but having no relevance to the application of Iowa Code chapter 88.

**875—10.13 to 10.18** Reserved.

**875—10.19(88) Special provisions for air contaminants.**

**10.19(1) Asbestos, tremolite, anthophyllite, and actinolite dust.** Reserved.

**10.19(2) Vinyl chloride.** Rule 1910.1017 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to vinyl chloride in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to vinyl chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

**10.19(3) Acrylonitrile.** Rule 1910.1045 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to acrylonitrile in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to acrylonitrile which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

**10.19(4) Inorganic arsenic.** Rule 1910.1018 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to inorganic arsenic in every employment

and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to inorganic arsenic which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

**10.19(5)** Rescinded, effective 6/10/87.

**10.19(6)** *Lead*. Rescinded IAB 8/5/92, effective 8/5/92.

**10.19(7)** *Ethylene oxide*. Rule 1910.1047 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to ethylene oxide in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to ethylene oxide which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

**10.19(8)** *Benzene*. Rule 1910.1028 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to benzene in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to benzene which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

**10.19(9)** *Formaldehyde*. Rule 1910.1048 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to formaldehyde in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to formaldehyde which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

**10.19(10)** *Methylene chloride*. Rule 1910.1052 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to methylene chloride in every employment and place of employment covered by 875—10.12(88) in lieu of any different standard on exposure to methylene chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

**875—10.20(88) Adoption by reference.** The rules beginning at 1910.20 and continuing through 1910, as adopted by the United States Secretary of Labor shall be the rules for implementing Iowa Code chapter 88. This rule adopts the Federal Occupational Safety and Health Standards of 29 CFR, Chapter XVII, Part 1910 as published at 37 Fed. Reg. 22102 to 22324 (October 18, 1972) and as amended at:

37 Fed. Reg. 23719 (November 8, 1972)  
37 Fed. Reg. 24749 (November 21, 1972)  
38 Fed. Reg. 3599 (February 8, 1973)  
38 Fed. Reg. 9079 (April 10, 1973)  
38 Fed. Reg. 10932 (May 3, 1973)  
38 Fed. Reg. 14373 (June 1, 1973)  
38 Fed. Reg. 16223 (June 21, 1973)  
38 Fed. Reg. 19030 (July 17, 1973)  
38 Fed. Reg. 27048 (September 28, 1973)  
38 Fed. Reg. 28035 (October 11, 1973)  
38 Fed. Reg. 33397 (December 4, 1973)  
39 Fed. Reg. 1437 (January 9, 1974)  
39 Fed. Reg. 3760 (January 29, 1974)  
39 Fed. Reg. 6110 (February 19, 1974)  
39 Fed. Reg. 9958 (March 15, 1974)  
39 Fed. Reg. 19468 (June 3, 1974)  
39 Fed. Reg. 35896 (October 4, 1974)  
39 Fed. Reg. 41846 (December 3, 1974)  
39 Fed. Reg. 41848 (December 3, 1974)  
40 Fed. Reg. 3982 (January 27, 1975)  
40 Fed. Reg. 13439 (March 26, 1975)  
40 Fed. Reg. 18446 (April 28, 1975)  
40 Fed. Reg. 23072 (May 28, 1975)  
40 Fed. Reg. 23743 (June 2, 1975)  
40 Fed. Reg. 24522 (June 9, 1975)

40 Fed. Reg. 27369 (June 27, 1975)  
40 Fed. Reg. 31598 (July 28, 1975)  
41 Fed. Reg. 11504 (March 19, 1976)  
41 Fed. Reg. 13352 (March 30, 1976)  
41 Fed. Reg. 35184 (August 20, 1976)  
41 Fed. Reg. 46784 (October 22, 1976)  
41 Fed. Reg. 55703 (December 21, 1976)  
42 Fed. Reg. 2956 (January 14, 1977)  
42 Fed. Reg. 3304 (January 18, 1977)  
42 Fed. Reg. 45544 (September 9, 1977)  
42 Fed. Reg. 46540 (September 16, 1977)  
42 Fed. Reg. 37668 (July 22, 1977)  
43 Fed. Reg. 11527 (March 17, 1978)  
43 Fed. Reg. 19624 (May 5, 1978)  
43 Fed. Reg. 27394 (June 23, 1978)  
43 Fed. Reg. 27434 (June 23, 1978)  
43 Fed. Reg. 28472 (June 30, 1978)  
43 Fed. Reg. 28473 (June 30, 1978)  
43 Fed. Reg. 31330 (July 21, 1978)  
43 Fed. Reg. 35032 (August 8, 1978)  
43 Fed. Reg. 45809 (October 3, 1978)  
43 Fed. Reg. 49744 (October 24, 1978)  
43 Fed. Reg. 51759 (November 7, 1978)  
43 Fed. Reg. 53007 (November 14, 1978)  
43 Fed. Reg. 56893 (December 5, 1978)  
43 Fed. Reg. 57602 (December 8, 1978)  
44 Fed. Reg. 5447 (January 26, 1979)  
44 Fed. Reg. 50338 (August 28, 1979)  
44 Fed. Reg. 60981 (October 23, 1979)  
44 Fed. Reg. 68827 (November 30, 1979)  
45 Fed. Reg. 6713 (January 29, 1980)  
45 Fed. Reg. 8594 (February 8, 1980)  
45 Fed. Reg. 12417 (February 26, 1980)  
45 Fed. Reg. 35277 (May 23, 1980)  
45 Fed. Reg. 41634 (June 20, 1980)  
45 Fed. Reg. 54333 (August 15, 1980)  
45 Fed. Reg. 60703 (September 12, 1980)  
46 Fed. Reg. 4056 (January 16, 1981)  
46 Fed. Reg. 6288 (January 21, 1981)  
46 Fed. Reg. 24557 (May 1, 1981)  
46 Fed. Reg. 32022 (June 19, 1981)  
46 Fed. Reg. 40185 (August 7, 1981)  
46 Fed. Reg. 2632 (August 21, 1981)  
46 Fed. Reg. 42632 (August 21, 1981)  
46 Fed. Reg. 45333 (September 11, 1981)  
46 Fed. Reg. 60775 (December 11, 1981)  
47 Fed. Reg. 39161 (September 7, 1982)  
47 Fed. Reg. 51117 (November 12, 1982)  
47 Fed. Reg. 53365 (November 26, 1982)  
48 Fed. Reg. 2768 (January 21, 1983)  
48 Fed. Reg. 9641 (March 8, 1983)  
48 Fed. Reg. 9776 (March 8, 1983)

48 Fed. Reg. 29687 (June 28, 1983)  
49 Fed. Reg. 881 (January 6, 1984)  
49 Fed. Reg. 4350 (February 3, 1984)  
49 Fed. Reg. 5321 (February 10, 1984)  
49 Fed. Reg. 25796 (June 22, 1984)  
50 Fed. Reg. 1050 (January 9, 1985)  
50 Fed. Reg. 4648 (February 1, 1985)  
50 Fed. Reg. 9800 (March 12, 1985)  
50 Fed. Reg. 36992 (September 11, 1985)  
50 Fed. Reg. 37353 (September 13, 1985)  
50 Fed. Reg. 41494 (October 11, 1985)  
50 Fed. Reg. 51173 (December 13, 1985)  
51 Fed. Reg. 22733 (June 20, 1986)  
51 Fed. Reg. 24325 (July 3, 1986)  
51 Fed. Reg. 25053 (July 10, 1986)  
51 Fed. Reg. 33033 (September 18, 1986)  
51 Fed. Reg. 33260 (September 19, 1986)  
51 Fed. Reg. 34560 (September 29, 1986)  
51 Fed. Reg. 45663 (December 19, 1986)  
52 Fed. Reg. 16241 (May 4, 1987)  
52 Fed. Reg. 17753 (May 12, 1987)  
52 Fed. Reg. 34562 (September 11, 1987)  
52 Fed. Reg. 36026 (September 25, 1987)  
52 Fed. Reg. 36387 (September 28, 1987)  
52 Fed. Reg. 46291 (December 4, 1987)  
52 Fed. Reg. 49624 (December 31, 1987)  
53 Fed. Reg. 6629 (March 2, 1988)  
53 Fed. Reg. 8352 (March 14, 1988)  
53 Fed. Reg. 11436 (April 6, 1988)  
53 Fed. Reg. 12120 (April 12, 1988)  
53 Fed. Reg. 16838 (May 11, 1988)  
53 Fed. Reg. 17695 (May 18, 1988)  
53 Fed. Reg. 27346 (July 20, 1988)  
53 Fed. Reg. 27960 (July 26, 1988)  
53 Fed. Reg. 34736 (September 8, 1988)  
53 Fed. Reg. 35625 (September 14, 1988)  
53 Fed. Reg. 37080 (September 23, 1988)  
53 Fed. Reg. 38162 (September 29, 1988)  
53 Fed. Reg. 39581 (October 7, 1988)  
53 Fed. Reg. 45080 (November 8, 1988)  
53 Fed. Reg. 47188 (November 22, 1988)  
53 Fed. Reg. 49981 (December 13, 1988)  
54 Fed. Reg. 2920 (January 19, 1989)  
54 Fed. Reg. 6888 (February 15, 1989)  
54 Fed. Reg. 9317 (March 6, 1989)  
54 Fed. Reg. 12792 (March 28, 1989)  
54 Fed. Reg. 28054 (July 5, 1989)  
54 Fed. Reg. 29274 (July 11, 1989)  
54 Fed. Reg. 29545 (July 13, 1989)  
54 Fed. Reg. 30704 (July 21, 1989)  
54 Fed. Reg. 31456 (July 28, 1989)  
54 Fed. Reg. 31765 (August 1, 1989)

54 Fed. Reg. 36687 (September 1, 1989)  
54 Fed. Reg. 36767 (September 5, 1989)  
54 Fed. Reg. 37531 (September 11, 1989)  
54 Fed. Reg. 41364 (October 6, 1989)  
54 Fed. Reg. 46610 (November 6, 1989)  
54 Fed. Reg. 47513 (November 15, 1989)  
54 Fed. Reg. 49971 (December 4, 1989)  
54 Fed. Reg. 50372 (December 6, 1989)  
54 Fed. Reg. 52024 (December 20, 1989)  
55 Fed. Reg. 3146 (January 30, 1990)  
55 Fed. Reg. 3300 (January 31, 1990)  
55 Fed. Reg. 3723 (February 5, 1990)  
55 Fed. Reg. 4998 (February 13, 1990)  
55 Fed. Reg. 7967 (March 6, 1990)  
55 Fed. Reg. 12110 (March 30, 1990)  
55 Fed. Reg. 12819 (April 6, 1990)  
55 Fed. Reg. 13696 (April 11, 1990)  
55 Fed. Reg. 14073 (April 13, 1990)  
55 Fed. Reg. 19259 (May 9, 1990)  
55 Fed. Reg. 25094 (June 10, 1990)  
55 Fed. Reg. 26431 (June 28, 1990)  
55 Fed. Reg. 32014 (August 6, 1990)  
55 Fed. Reg. 38677 (September 20, 1990)  
55 Fed. Reg. 46053 (November 1, 1990)  
55 Fed. Reg. 46949 (November 8, 1990)  
55 Fed. Reg. 50686 (December 10, 1990)  
56 Fed. Reg. 15832 (April 18, 1991)  
56 Fed. Reg. 24686 (May 31, 1991)  
56 Fed. Reg. 43700 (September 4, 1991)  
56 Fed. Reg. 64175 (December 6, 1991)  
57 Fed. Reg. 6403 (February 24, 1992)  
57 Fed. Reg. 7847 (March 4, 1992)  
57 Fed. Reg. 7878 (March 5, 1992)  
57 Fed. Reg. 22307 (May 27, 1992)  
57 Fed. Reg. 24330 (June 8, 1992)  
57 Fed. Reg. 24701 (June 10, 1992)  
57 Fed. Reg. 27160 (June 18, 1992)  
57 Fed. Reg. 29204 (July 1, 1992)  
57 Fed. Reg. 29206 (July 1, 1992)  
57 Fed. Reg. 35666 (August 10, 1992)  
57 Fed. Reg. 42388 (September 14, 1992)  
58 Fed. Reg. 4549 (January 14, 1993)  
58 Fed. Reg. 15089 (March 19, 1993)  
58 Fed. Reg. 16496 (March 29, 1993)  
58 Fed. Reg. 21778 (April 23, 1993)  
58 Fed. Reg. 34845 (June 29, 1993)  
58 Fed. Reg. 35308 (June 30, 1993)  
58 Fed. Reg. 35340 (June 30, 1993)  
58 Fed. Reg. 40191 (July 27, 1993)  
59 Fed. Reg. 4435 (January 31, 1994)  
59 Fed. Reg. 6169 (February 9, 1994)  
59 Fed. Reg. 16360 (April 6, 1994)

59 Fed. Reg. 26115 (May 19, 1994)  
59 Fed. Reg. 33661 (June 30, 1994)  
59 Fed. Reg. 33910 (July 1, 1994)  
59 Fed. Reg. 36699 (July 19, 1994)  
59 Fed. Reg. 40729 (August 9, 1994)  
59 Fed. Reg. 41057 (August 10, 1994)  
59 Fed. Reg. 43270 (August 22, 1994)  
59 Fed. Reg. 51741 (October 12, 1994)  
59 Fed. Reg. 65948 (December 22, 1994)  
60 Fed. Reg. 9624 (February 21, 1995)  
60 Fed. Reg. 11194 (March 1, 1995)  
60 Fed. Reg. 33344 (June 28, 1995)  
60 Fed. Reg. 33984 (June 29, 1995)  
60 Fed. Reg. 47035 (September 8, 1995)  
60 Fed. Reg. 52859 (October 11, 1995)  
61 Fed. Reg. 5508 (February 13, 1996)  
61 Fed. Reg. 9230 (March 7, 1996)  
61 Fed. Reg. 9583 (March 8, 1996)  
61 Fed. Reg. 19548 (May 2, 1996)  
61 Fed. Reg. 21228 (May 9, 1996)  
61 Fed. Reg. 31430 (June 20, 1996)  
61 Fed. Reg. 43456 (August 23, 1996)  
61 Fed. Reg. 56831 (November 4, 1996)  
62 Fed. Reg. 1600 (January 10, 1997)  
62 Fed. Reg. 29668 (June 2, 1997)  
62 Fed. Reg. 40195 (July 25, 1997)  
62 Fed. Reg. 42018 (August 4, 1997)  
62 Fed. Reg. 42666 (August 8, 1997)  
62 Fed. Reg. 43581 (August 14, 1997)  
62 Fed. Reg. 48175 (September 15, 1997)  
62 Fed. Reg. 54383 (October 20, 1997)  
62 Fed. Reg. 65203 (December 11, 1997)  
62 Fed. Reg. 66276 (December 18, 1997)  
63 Fed. Reg. 1269 (January 8, 1998)  
63 Fed. Reg. 13339 (March 19, 1998)  
63 Fed. Reg. 17093 (April 8, 1998)  
63 Fed. Reg. 20098 (April 23, 1998)  
63 Fed. Reg. 33467 (June 18, 1998)  
63 Fed. Reg. 50729 (September 22, 1998)  
63 Fed. Reg. 66038 (December 1, 1998)  
63 Fed. Reg. 66270 (December 1, 1998)  
64 Fed. Reg. 13700 (March 22, 1999)  
64 Fed. Reg. 13908 (March 23, 1999)  
64 Fed. Reg. 22552 (April 27, 1999)  
65 Fed. Reg. 76567 (December 7, 2000)  
66 Fed. Reg. 5324 (January 18, 2001)  
66 Fed. Reg. 18191 (April 6, 2001)  
67 Fed. Reg. 67961 (November 7, 2002)  
68 Fed. Reg. 75780 (December 31, 2003)  
69 Fed. Reg. 7363 (February 17, 2004)  
69 Fed. Reg. 31881 (June 8, 2004)  
69 Fed. Reg. 46993 (August 4, 2004)

70 Fed. Reg. 53929 (September 13, 2005)  
 70 Fed. Reg. 1140 (January 5, 2005)  
 71 Fed. Reg. 10373 (February 28, 2006)  
 71 Fed. Reg. 36008 (June 23, 2006)  
 71 Fed. Reg. 63242 (October 30, 2006)  
 72 Fed. Reg. 7190 (February 14, 2007)  
 72 Fed. Reg. 64428 (November 15, 2007)  
 72 Fed. Reg. 71068 (December 14, 2007)  
 73 Fed. Reg. 75583 (December 12, 2008)  
 68 Fed. Reg. 32638 (June 2, 2003)  
 74 Fed. Reg. 46355 (September 9, 2009)  
 74 Fed. Reg. 40447 (August 11, 2009)  
 75 Fed. Reg. 12685 (March 17, 2010)  
 76 Fed. Reg. 33606 (June 8, 2011)  
 76 Fed. Reg. 75786 (December 5, 2011)  
 77 Fed. Reg. 17764 (March 26, 2012)  
 76 Fed. Reg. 80738 (December 27, 2011)  
 77 Fed. Reg. 37598 (June 22, 2012)  
 77 Fed. Reg. 46949 (August 7, 2012)  
 78 Fed. Reg. 9313 (February 8, 2013)  
 78 Fed. Reg. 69549 (November 20, 2013)  
 79 Fed. Reg. 20629 (April 11, 2014)  
 79 Fed. Reg. 56960 (September 24, 2014)  
 80 Fed. Reg. 60036 (October 5, 2015)  
 81 Fed. Reg. 16090 (March 25, 2016)  
 81 Fed. Reg. 16861 (March 25, 2016)  
 81 Fed. Reg. 82981 (November 18, 2016)  
 82 Fed. Reg. 2735 (January 9, 2017)  
 83 Fed. Reg. 19948 (May 7, 2018)  
 84 Fed. Reg. 21457 (May 14, 2019)  
 84 Fed. Reg. 50755 (September 26, 2019)  
 84 Fed. Reg. 68795 (December 17, 2019)  
 85 Fed. Reg. 8731 (February 18, 2020)

[ARC 7699B, IAB 4/8/09, effective 5/13/09; ARC 8088B, IAB 9/9/09, effective 10/14/09; ARC 8395B, IAB 12/16/09, effective 1/20/10; ARC 8522B, IAB 2/10/10, effective 3/17/10; ARC 8997B, IAB 8/11/10, effective 9/15/10; ARC 9755B, IAB 9/21/11, effective 10/26/11; ARC 0173C, IAB 6/13/12, effective 7/18/12; ARC 0282C, IAB 8/22/12, effective 9/26/12; ARC 0726C, IAB 5/1/13, effective 6/5/13; ARC 0898C, IAB 8/7/13, effective 9/11/13; ARC 1509C, IAB 6/25/14, effective 7/30/14; ARC 1531C, IAB 7/9/14, effective 8/13/14; ARC 1803C, IAB 12/24/14, effective 1/28/15; ARC 2595C, IAB 6/22/16, effective 7/27/16; ARC 2959C, IAB 3/1/17, effective 4/5/17; ARC 3721C, IAB 3/28/18, effective 5/11/18; ARC 4071C, IAB 10/10/18, effective 11/14/18; ARC 4640C, IAB 8/28/19, effective 10/2/19; ARC 5005C, IAB 3/25/20, effective 4/29/20; ARC 5158C, IAB 8/26/20, effective 9/30/20]

These rules are intended to implement Iowa Code section 88.5.

[Filed 7/13/72; amended 8/29/72, 12/1/72, 8/16/73, 10/11/73, 3/18/74, 6/12/74, 12/3/74, 3/13/75]

[Filed 2/20/76, Notice 12/29/75—published 3/8/76, effective 4/15/76]

[Filed 6/21/76, Notice 5/17/76—published 7/12/76, effective 8/20/76]

[Filed 4/13/77, Notice 3/9/77—published 5/4/77, effective 6/9/77]

[Filed emergency 10/13/77—published 11/2/77, effective 10/13/77]

[Filed 11/3/78, Notice 9/20/78—published 11/29/78, effective 1/10/79]

[Filed emergency 2/2/79—published 2/21/79, effective 2/2/79]

[Filed 8/1/80, Notice 6/25/80—published 8/20/80, effective 9/25/80]

[Filed emergency 6/15/81—published 7/8/81, effective 6/15/81]

[Filed 8/12/81, Notice 7/8/81—published 9/2/81, effective 10/9/81]

[Filed 4/22/83, Notice 3/16/83—published 5/11/83, effective 6/15/83]

[Filed 5/20/83, Notice 4/13/83—published 6/8/83, effective 7/15/83]

[Filed emergency after Notice 7/1/83, Notice 3/16/83—published 7/20/83, effective 7/1/83]



[Filed 7/12/84, Notice 3/14/84—published 8/1/84, effective 9/5/84]  
[Filed emergency 5/8/85—published 6/5/85, effective 5/8/85]  
[Filed 9/5/85, Notice 5/8/85—published 9/25/85, effective 10/30/85]  
[Filed 12/30/85, Notice 10/23/85—published 1/15/86, effective 2/19/86]  
[Filed 3/21/86, Notice 12/18/85—published 4/9/86, effective 5/25/86]  
[Filed emergency 6/27/86—published 7/16/86, effective 7/21/86]  
[Filed 6/27/86, Notice 3/26/86—published 7/16/86, effective 8/20/86]  
[Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]  
[Filed emergency 10/1/86—published 10/22/86, effective 10/1/86]  
[Filed 10/1/86, Notice 7/16/86—published 10/22/86, effective 11/26/86]  
[Filed emergency 4/17/87—published 5/6/87, effective 4/17/87]  
[Filed 4/17/87, Notice 9/24/86—published 5/6/87, effective 6/10/87]  
[Filed emergency 5/1/87—published 5/20/87, effective 5/1/87]  
[Filed emergency 5/14/87—published 6/3/87, effective 5/14/87]  
[Filed 5/12/87, Notice 10/22/86—published 6/3/87, effective 7/8/87]  
[Filed emergency 6/15/87—published 7/1/87, effective 6/15/87]  
[Filed 8/6/87, Notice 5/6/87—published 8/26/87, effective 9/30/87]  
[Filed 8/6/87, Notice 5/20/87—published 8/26/87, effective 9/30/87]  
[Filed 8/6/87, Notice 6/3/87—published 8/26/87, effective 9/30/87]  
[Filed 8/6/87, Notice 7/1/87—published 8/26/87, effective 9/30/87]  
[Filed 4/25/88, Notice 12/16/87—published 5/18/88, effective 6/22/88]  
[Filed 7/8/88, Notice 5/18/88—published 7/27/88, effective 9/1/88]  
[Filed 8/30/88, Notice 6/15/88—published 9/21/88, effective 11/1/88]  
[Filed 3/17/89, Notices 9/21/88, 10/5/88, 10/19/88—published 4/5/89, effective 5/10/89]  
[Filed 5/25/89, Notice 4/5/89—published 6/14/89, effective 7/20/89]  
[Filed 8/18/89, Notice 6/14/89—published 9/6/89, effective 10/11/89]  
[Filed 10/26/89, Notice 9/6/89—published 11/15/89, effective 12/20/89]  
[Filed 1/19/90, Notice 11/15/89—published 2/7/90, effective 3/14/90]  
[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 5/9/90]  
[Filed 6/8/90, Notice 4/4/90—published 6/27/90, effective 8/1/90]  
[Filed 11/9/90, Notice 6/27/90—published 11/28/90, effective 1/2/91]  
[Filed 2/15/91, Notice 11/28/90—published 3/6/91, effective 4/10/91]  
[Filed 4/23/91, Notice 3/6/91—published 5/15/91, effective 6/19/91]  
[Filed 6/28/91, Notice 5/15/91—published 7/24/91, effective 8/28/91]  
[Filed 9/27/91, Notice 7/24/91—published 10/16/91, effective 11/20/91]  
[Filed 12/20/91, Notice 10/30/91—published 1/8/92, effective 2/12/92]  
[Filed emergency 2/12/92 after Notice 1/8/92—published 3/4/92, effective 3/4/92]  
[Filed emergency 5/6/92 after Notice 4/1/92—published 5/27/92, effective 5/27/92]  
[Filed emergency 7/17/92—published 8/5/92, effective 8/5/92]  
[Filed emergency 7/29/92 after Notice 6/24/92—published 8/19/92, effective 8/19/92]  
[Filed emergency 8/14/92 after Notice 7/8/92—published 9/2/92, effective 9/2/92]  
[Filed emergency 9/11/92 after Notice 8/5/92—published 9/30/92, effective 9/30/92]  
[Filed emergency 10/7/92 after Notice 9/2/92—published 10/28/92, effective 10/28/92]  
[Filed emergency 12/4/92 after Notice 10/28/92—published 12/23/92, effective 12/23/92]  
[Filed emergency 3/22/93 after Notice 2/17/93—published 4/14/93, effective 4/14/93]  
[Filed emergency 6/4/93 after Notice 4/28/93—published 6/23/93, effective 6/23/93]  
[Filed emergency 7/29/93 after Notice 5/26/93—published 8/18/93, effective 8/18/93]  
[Filed emergency 9/22/93 after Notice 8/18/93—published 10/13/93, effective 10/13/93]  
[Filed emergency 10/7/93 after Notice 9/1/93—published 10/27/93, effective 10/27/93]  
[Filed emergency 4/21/94 after Notice 3/16/94—published 5/11/94, effective 5/11/94]  
[Filed emergency 6/15/94 after Notice 5/11/94—published 7/6/94, effective 7/6/94]  
[Filed emergency 8/26/94 after Notice 7/20/94—published 9/14/94, effective 9/14/94]

[Filed emergency 9/9/94 after Notice 8/3/94—published 9/28/94, effective 9/28/94]  
[Filed emergency 9/23/94 after Notice 8/17/94—published 10/12/94, effective 10/12/94]  
[Filed emergency 10/21/94 after Notice 9/14/94—published 11/9/94, effective 11/9/94]  
[Filed emergency 11/2/94 after Notice 9/28/94—published 11/23/94, effective 11/23/94]  
[Filed emergency 1/4/95 after Notice 11/9/94—published 2/1/95, effective 2/1/95]  
[Filed emergency 4/21/95 after Notice 3/15/95—published 5/10/95, effective 5/10/95]  
[Filed emergency 7/14/95 after Notice 5/10/95—published 8/2/95, effective 8/2/95]  
[Filed emergency 9/22/95 after Notice 8/16/95—published 10/11/95, effective 10/11/95]  
[Filed emergency 12/1/95 after Notice 10/11/95—published 12/20/95, effective 12/20/95]  
[Filed emergency 1/26/96 after Notice 12/20/95—published 2/14/96, effective 2/14/96]  
[Filed emergency 7/12/96 after Notice 5/22/96—published 7/31/96, effective 7/31/96]  
[Filed emergency 10/3/96 after Notice 7/31/96—published 10/23/96, effective 10/23/96]  
[Filed emergency 11/27/96 after Notice 10/23/96—published 12/18/96, effective 12/18/96]  
[Filed emergency 2/7/97 after Notice 12/18/96—published 2/26/97, effective 2/26/97]  
[Filed emergency 4/4/97 after Notice 2/26/97—published 4/23/97, effective 4/23/97]  
[Filed emergency 12/11/97 after Notice 10/22/97—published 12/31/97, effective 12/31/97]  
[Filed emergency 3/19/98 after Notice 2/11/98—published 4/8/98, effective 4/8/98]  
[Filed emergency 9/4/98 after Notice 7/29/98—published 9/23/98, effective 9/23/98]  
[Filed emergency 10/30/98 after Notice 9/23/98—published 11/18/98, effective 11/18/98]  
[Filed emergency 1/8/99 after Notice 11/18/98—published 1/27/99, effective 1/27/99]  
[Filed emergency 3/5/99 after Notice 1/27/99—published 3/24/99, effective 3/24/99]  
[Filed emergency 1/5/00 after Notice 8/25/99—published 1/26/00, effective 1/26/00]  
[Filed 7/20/01, Notice 6/13/01—published 8/8/01, effective 9/12/01]  
[Filed 11/20/01, Notice 6/13/01—published 12/12/01, effective 1/16/02]  
[Filed 3/14/03, Notice 2/5/03—published 4/2/03, effective 5/7/03]  
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 8/4/04]  
[Filed 10/28/04, Notice 7/21/04—published 11/24/04, effective 12/29/04]  
[Filed 2/10/06, Notice 12/21/05—published 3/1/06, effective 4/5/06]  
[Filed 3/29/06, Notice 1/18/06—published 3/29/06, effective 5/3/06]  
[Filed 6/14/06, Notice 5/10/06—published 7/5/06, effective 8/9/06]  
[Filed emergency 7/28/06—published 8/16/06, effective 8/28/06]  
[Filed 1/10/07, Notice 12/6/06—published 1/31/07, effective 3/7/07]  
[Filed 5/16/07, Notice 4/11/07—published 6/6/07, effective 8/13/07]  
[Filed 2/8/08, Notice 1/2/08—published 2/27/08, effective 5/15/08]  
[Filed 6/24/08, Notice 5/7/08—published 7/16/08, effective 8/20/08]  
[Filed ARC 7699B (Notice ARC 7541B, IAB 2/11/09), IAB 4/8/09, effective 5/13/09]  
[Filed ARC 8088B (Notice ARC 7927B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]  
[Filed ARC 8395B (Notice ARC 8241B, IAB 10/21/09), IAB 12/16/09, effective 1/20/10]  
[Filed ARC 8522B (Notice ARC 8378B, IAB 12/16/09), IAB 2/10/10, effective 3/17/10]  
[Filed ARC 8997B (Notice ARC 8862B, IAB 6/16/10), IAB 8/11/10, effective 9/15/10]  
[Filed ARC 9755B (Notice ARC 9640B, IAB 7/27/11), IAB 9/21/11, effective 10/26/11]  
[Filed ARC 0173C (Notice ARC 0105C, IAB 4/18/12), IAB 6/13/12, effective 7/18/12]  
[Filed ARC 0282C (Notice ARC 0175C, IAB 6/27/12), IAB 8/22/12, effective 9/26/12]  
[Filed ARC 0726C (Notice ARC 0587C, IAB 2/6/13), IAB 5/1/13, effective 6/5/13]  
[Filed ARC 0898C (Notice ARC 0752C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]  
[Filed ARC 1509C (Notice ARC 1440C, IAB 4/30/14), IAB 6/25/14, effective 7/30/14]  
[Filed ARC 1531C (Notice ARC 1461C, IAB 5/14/14), IAB 7/9/14, effective 8/13/14]  
[Filed ARC 1803C (Notice ARC 1687C, IAB 10/29/14), IAB 12/24/14, effective 1/28/15]  
[Filed ARC 2595C (Notice ARC 2516C, IAB 4/27/16), IAB 6/22/16, effective 7/27/16]  
[Filed ARC 2959C (Notice ARC 2866C, IAB 12/21/16), IAB 3/1/17, effective 4/5/17]  
[Filed ARC 3721C (Notice ARC 3593C, IAB 1/31/18), IAB 3/28/18, effective 5/11/18]  
[Filed ARC 4071C (Notice ARC 3955C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

[Filed ARC 4640C (Notice ARC 4520C, IAB 7/3/19), IAB 8/28/19, effective 10/2/19]  
[Filed ARC 5005C (Notice ARC 4882C, IAB 1/29/20), IAB 3/25/20, effective 4/29/20]  
[Filed ARC 5158C (Notice ARC 4996C, IAB 3/25/20), IAB 8/26/20, effective 9/30/20]



CHAPTER 26  
CONSTRUCTION SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 26]

**875—26.1(88) Adoption by reference.** Federal Safety and Health Regulations for Construction beginning at 29 CFR 1926.16 and continuing through 29 CFR, Chapter XVII, Part 1926, are hereby adopted by reference for implementation of Iowa Code chapter 88. These federal rules shall apply and be interpreted to apply to the Iowa Occupational Safety and Health Act, Iowa Code chapter 88, not the Contract Work Hours and Safety Standards Act, and shall apply and be interpreted to apply to enforcement by the Iowa commissioner of labor, not the United States Secretary of Labor or the Federal Occupational Safety and Health Administration. The amendments to 29 CFR 1926 are adopted as published at:

38 Fed. Reg. 16856 (June 27, 1973)  
38 Fed. Reg. 27594 (October 5, 1973)  
38 Fed. Reg. 33397 (December 4, 1973)  
39 Fed. Reg. 19470 (June 3, 1974)  
39 Fed. Reg. 24361 (July 2, 1974)  
40 Fed. Reg. 23072 (May 28, 1975)  
41 Fed. Reg. 55703 (December 21, 1976)  
42 Fed. Reg. 2956 (January 14, 1977)  
42 Fed. Reg. 37668 (July 22, 1977)  
43 Fed. Reg. 56894 (December 5, 1978)  
45 Fed. Reg. 75626 (November 14, 1980)  
51 Fed. Reg. 22733 (June 20, 1986)  
51 Fed. Reg. 25318 (July 11, 1986)  
52 Fed. Reg. 17753 (May 12, 1987)  
52 Fed. Reg. 36381 (September 28, 1987)  
52 Fed. Reg. 46291 (December 4, 1987)  
53 Fed. Reg. 22643 (June 16, 1988)  
53 Fed. Reg. 27346 (July 20, 1988)  
53 Fed. Reg. 29139 (August 2, 1988)  
53 Fed. Reg. 35627 (September 14, 1988)  
53 Fed. Reg. 35953 (September 15, 1988)  
53 Fed. Reg. 36009 (September 16, 1988)  
53 Fed. Reg. 37080 (September 23, 1988)  
54 Fed. Reg. 15405 (April 18, 1989)  
54 Fed. Reg. 23850 (June 2, 1989)  
54 Fed. Reg. 30705 (July 21, 1989)  
54 Fed. Reg. 41088 (October 5, 1989)  
54 Fed. Reg. 45894 (October 31, 1989)  
54 Fed. Reg. 49279 (November 30, 1989)  
54 Fed. Reg. 52024 (December 20, 1989)  
54 Fed. Reg. 53055 (December 27, 1989)  
55 Fed. Reg. 3732 (February 5, 1990)  
55 Fed. Reg. 42328 (October 18, 1990)  
55 Fed. Reg. 47687 (November 14, 1990)  
55 Fed. Reg. 50687 (December 10, 1990)  
56 Fed. Reg. 2585 (January 23, 1991)  
56 Fed. Reg. 5061 (February 7, 1991)  
56 Fed. Reg. 41794 (August 23, 1991)  
56 Fed. Reg. 43700 (September 4, 1991)

57 Fed. Reg. 7878 (March 5, 1992)  
57 Fed. Reg. 24330 (June 8, 1992)  
57 Fed. Reg. 29119 (June 30, 1992)  
57 Fed. Reg. 35681 (August 10, 1992)  
57 Fed. Reg. 42452 (September 14, 1992)  
58 Fed. Reg. 21778 (April 23, 1993)  
58 Fed. Reg. 26627 (May 4, 1993)  
58 Fed. Reg. 35077 (June 30, 1993)  
58 Fed. Reg. 35310 (June 30, 1993)  
58 Fed. Reg. 40468 (July 28, 1993)  
59 Fed. Reg. 215 (January 3, 1994)  
59 Fed. Reg. 6170 (February 9, 1994)  
59 Fed. Reg. 36699 (July 19, 1994)  
59 Fed. Reg. 40729 (August 9, 1994)  
59 Fed. Reg. 41131 (August 10, 1994)  
59 Fed. Reg. 43275 (August 22, 1994)  
59 Fed. Reg. 65948 (December 22, 1994)  
60 Fed. Reg. 9625 (February 21, 1995)  
60 Fed. Reg. 11194 (March 1, 1995)  
60 Fed. Reg. 33345 (June 28, 1995)  
60 Fed. Reg. 34001 (June 29, 1995)  
60 Fed. Reg. 36044 (July 13, 1995)  
60 Fed. Reg. 39255 (August 2, 1995)  
60 Fed. Reg. 50412 (September 29, 1995)  
61 Fed. Reg. 5509 (February 13, 1996)  
61 Fed. Reg. 9248 (March 7, 1996)  
61 Fed. Reg. 31431 (June 20, 1996)  
61 Fed. Reg. 41738 (August 12, 1996)  
61 Fed. Reg. 43458 (August 23, 1996)  
61 Fed. Reg. 46104 (August 30, 1996)  
61 Fed. Reg. 56856 (November 4, 1996)  
61 Fed. Reg. 59831 (November 25, 1996)  
62 Fed. Reg. 1619 (January 10, 1997)  
63 Fed. Reg. 1295 (January 8, 1998)  
63 Fed. Reg. 1919 (January 13, 1998)  
63 Fed. Reg. 3814 (January 27, 1998)  
63 Fed. Reg. 13340 (March 19, 1998)  
63 Fed. Reg. 17094 (April 8, 1998)  
63 Fed. Reg. 20099 (April 23, 1998)  
63 Fed. Reg. 33468 (June 18, 1998)  
63 Fed. Reg. 35138 (June 29, 1998)  
63 Fed. Reg. 66274 (December 1, 1998)  
64 Fed. Reg. 22552 (April 27, 1999)  
66 Fed. Reg. 5265 (January 18, 2001)  
66 Fed. Reg. 37137 (July 17, 2001)  
67 Fed. Reg. 57736 (September 12, 2002)  
69 Fed. Reg. 31881 (June 8, 2004)  
70 Fed. Reg. 1143 (January 5, 2005)  
71 Fed. Reg. 2885 (January 18, 2006)  
70 Fed. Reg. 76985 (December 29, 2005)  
71 Fed. Reg. 10381 (February 28, 2006)  
71 Fed. Reg. 36008 (June 23, 2006)

71 Fed. Reg. 76985 (August 24, 2006)  
 72 Fed. Reg. 64428 (November 15, 2007)  
 73 Fed. Reg. 75583 (December 12, 2008)  
 75 Fed. Reg. 12685 (March 17, 2010)  
 75 Fed. Reg. 27429 (May 17, 2010)  
 75 Fed. Reg. 48130 (August 9, 2010)  
 76 Fed. Reg. 33606 (June 8, 2011)  
 77 Fed. Reg. 17764 (March 26, 2012)  
 76 Fed. Reg. 80738 (December 27, 2011)  
 77 Fed. Reg. 23118 (April 18, 2012)  
 77 Fed. Reg. 37598 (June 22, 2012)  
 77 Fed. Reg. 42988 (July 23, 2012)  
 77 Fed. Reg. 46949 (August 7, 2012)  
 78 Fed. Reg. 23841 (April 23, 2013)  
 78 Fed. Reg. 32116 (May 29, 2013)  
 79 Fed. Reg. 20629 (April 11, 2014)  
 79 Fed. Reg. 56960 (September 24, 2014)  
 79 Fed. Reg. 57798 (September 26, 2014)  
 80 Fed. Reg. 25518 (May 4, 2015)  
 80 Fed. Reg. 60039 (October 5, 2015)  
 81 Fed. Reg. 16092 (March 25, 2016)  
 81 Fed. Reg. 16875 (March 25, 2016)  
 83 Fed. Reg. 56244 (November 9, 2018)  
 84 Fed. Reg. 21574 (May 14, 2019)  
 85 Fed. Reg. 8735 (February 18, 2020)

This rule is intended to implement Iowa Code sections 84A.1, 84A.2, 88.2 and 88.5.

[ARC 7699B, IAB 4/8/09, effective 5/13/09; ARC 8997B, IAB 8/11/10, effective 9/15/10; ARC 9230B, IAB 11/17/10, effective 12/22/10; ARC 9755B, IAB 9/21/11, effective 10/26/11; ARC 0173C, IAB 6/13/12, effective 7/18/12; ARC 0282C, IAB 8/22/12, effective 9/26/12; ARC 0726C, IAB 5/1/13, effective 6/5/13; ARC 0898C, IAB 8/7/13, effective 9/11/13; ARC 1049C, IAB 10/2/13, effective 11/6/13; ARC 1531C, IAB 7/9/14, effective 8/13/14; ARC 1803C, IAB 12/24/14, effective 1/28/15; ARC 1908C, IAB 3/18/15, effective 4/22/15; ARC 2136C, IAB 9/16/15, effective 10/21/15; ARC 2595C, IAB 6/22/16, effective 7/27/16; ARC 4320C, IAB 2/27/19, effective 4/3/19; ARC 4640C, IAB 8/28/19, effective 10/2/19; ARC 5158C, IAB 8/26/20, effective 9/30/20]

**875—26.2(88) Beryllium exposure limits.** Effective May 11, 2018, the eight-hour time-weighted average permissible exposure limit for beryllium is 0.2 micrograms per cubic liter, and the short-term exposure limit for beryllium is 2.0 micrograms per cubic meter over a 15-minute sampling period.

This rule is intended to implement Iowa Code section 88.5.

[ARC 3721C, IAB 3/28/18, effective 5/11/18]

[Filed 7/13/72; amended 8/29/72, 8/16/73, 10/11/73, 3/18/74, 12/3/74]  
 [Filed 2/20/76, Notice 12/29/75—published 3/8/76, effective 4/15/76]  
 [Filed 4/13/77, Notice 3/9/77—published 5/4/77, effective 6/9/77]  
 [Filed 11/3/78, Notice 9/20/78—published 11/29/78, effective 1/10/79]  
 [Filed 8/1/80, Notice 6/25/80—published 8/20/80, effective 9/25/80]  
 [Filed 8/12/81, Notice 7/8/81—published 9/2/81, effective 10/9/81]  
 [Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]  
 [Filed emergency 10/1/86—published 10/22/86, effective 10/1/86]  
 [Filed 4/17/87, Notice 9/24/86—published 5/6/87, effective 6/10/87]  
 [Filed 4/17/87, Notice 10/22/86—published 5/6/87, effective 6/10/87]  
 [Filed emergency 6/15/87—published 7/1/87, effective 6/15/87]  
 [Filed 8/6/87, Notice 7/1/87—published 8/26/87, effective 9/30/87]  
 [Filed 7/8/88, Notice 5/18/88—published 7/27/88, effective 9/1/88]  
 [Filed 3/17/89, Notices 9/21/88, 10/19/88—published 4/5/89, effective 5/10/89]  
 [Filed 8/18/89, Notices 6/14/89, 6/28/89—published 9/6/89, effective 10/11/89]  
 [Filed 10/26/89, Notice 9/6/89—published 11/15/89, effective 12/20/89]

[Filed 1/19/90, Notice 11/15/89—published 2/7/90, effective 3/14/90]  
[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 5/9/90]  
[Filed 6/8/90, Notice 4/4/90—published 6/27/90, effective 8/1/90]  
[Filed 2/15/91, Notice 11/28/90—published 3/6/91, effective 4/10/91]  
[Filed 4/23/91, Notice 3/6/91—published 5/15/91, effective 6/19/91]  
[Filed 12/20/91, Notice 10/30/91—published 1/8/92, effective 2/12/92]  
[Filed emergency 2/12/92 after Notice 1/8/92—published 3/4/92, effective 3/4/92]  
[Filed emergency 5/6/92 after Notice 4/1/92—published 5/27/92, effective 5/27/92]  
[Filed emergency 7/17/92—published 8/5/92, effective 8/5/92]  
[Filed emergency 8/14/92 after Notice 7/8/92—published 9/2/92, effective 9/2/92]  
[Filed emergency 9/11/92 after Notice 8/5/92—published 9/30/92, effective 9/30/92]  
[Filed emergency 10/7/92 after Notice 9/2/92—published 10/28/92, effective 10/28/92]  
[Filed emergency 12/4/92 after Notice 10/28/92—published 12/23/92, effective 12/23/92]  
[Filed emergency 7/29/93 after Notices 5/26/93, 6/9/93—published 8/18/93, effective 8/18/93]  
[Filed emergency 9/22/93 after Notice 8/18/93—published 10/13/93, effective 10/13/93]  
[Filed emergency 10/7/93 after Notice 9/1/93—published 10/27/93, effective 10/27/93]  
[Filed emergency 4/21/94 after Notice 3/16/94—published 5/11/94, effective 5/11/94]  
[Filed emergency 9/23/94 after Notice 8/17/94—published 10/12/94, effective 10/12/94]  
[Filed emergency 10/21/94 after Notice 9/14/94—published 11/9/94, effective 11/9/94]  
[Filed emergency 11/2/94 after Notice 9/28/94—published 11/23/94, effective 11/23/94]  
[Filed emergency 4/21/95 after Notice 3/15/95—published 5/10/95, effective 5/10/95]  
[Filed emergency 7/14/95 after Notice 5/10/95—published 8/2/95, effective 8/2/95]  
[Filed emergency 9/22/95 after Notice 8/16/95—published 10/11/95, effective 10/11/95]  
[Filed emergency 12/1/95 after Notice 10/11/95—published 12/20/95, effective 12/20/95]  
[Filed emergency 1/26/96 after Notice 12/20/95—published 2/14/96, effective 2/14/96]  
[Filed emergency 7/12/96 after Notice 5/22/96—published 7/31/96, effective 7/31/96]  
[Filed emergency 10/3/96 after Notice 7/31/96—published 10/23/96, effective 10/23/96]  
[Filed emergency 11/27/96 after Notice 10/23/96—published 12/18/96, effective 12/18/96]  
[Filed emergency 2/7/97 after Notice 12/18/96—published 2/26/97, effective 2/26/97]  
[Filed emergency 4/4/97 after Notice 2/26/97—published 4/23/97, effective 4/23/97]  
[Filed emergency 3/19/98 after Notice 2/11/98—published 4/8/98, effective 4/8/98]  
[Filed emergency 7/10/98 after Notice 4/8/98—published 7/29/98, effective 7/29/98]  
[Filed emergency 9/4/98 after Notice 7/29/98—published 9/23/98, effective 9/23/98]  
[Filed emergency 10/30/98 after Notice 9/23/98—published 11/18/98, effective 11/18/98]  
[Filed emergency 3/5/99 after Notice 1/27/99—published 3/24/99, effective 3/24/99]  
[Filed emergency 1/5/00 after Notice 8/25/99—published 1/26/00, effective 1/26/00]  
[Filed 11/20/01, Notice 6/13/01—published 12/12/01, effective 1/16/02]  
[Filed 11/21/01, Notice 10/17/01—published 12/12/01, effective 1/16/02]  
[Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]  
[Filed 10/28/04, Notice 7/21/04—published 11/24/04, effective 12/29/04]  
[Filed 3/9/06, Notice 1/18/06—published 3/29/06, effective 5/3/06]  
[Filed 4/18/06, Notice 3/1/06—published 5/10/06, effective 6/14/06]  
[Filed 6/14/06, Notice 5/10/06—published 7/5/06, effective 8/9/06]  
[Filed emergency 7/28/06—published 8/16/06, effective 8/28/06]  
[Filed 1/10/07, Notice 12/6/06—published 1/31/07, effective 3/7/07]  
[Filed 2/8/08, Notice 1/2/08—published 2/27/08, effective 5/15/08]  
[Filed ARC 7699B (Notice ARC 7541B, IAB 2/11/09), IAB 4/8/09, effective 5/13/09]  
[Filed ARC 8997B (Notice ARC 8862B, IAB 6/16/10), IAB 8/11/10, effective 9/15/10]  
[Filed ARC 9230B (Notice ARC 9090B, IAB 9/22/10), IAB 11/17/10, effective 12/22/10]  
[Filed ARC 9755B (Notice ARC 9640B, IAB 7/27/11), IAB 9/21/11, effective 10/26/11]  
[Filed ARC 0173C (Notice ARC 0105C, IAB 4/18/12), IAB 6/13/12, effective 7/18/12]  
[Filed ARC 0282C (Notice ARC 0175C, IAB 6/27/12), IAB 8/22/12, effective 9/26/12]



[Filed ARC 0726C (Notice ARC 0587C, IAB 2/6/13), IAB 5/1/13, effective 6/5/13]  
[Filed ARC 0898C (Notice ARC 0752C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13]  
[Filed ARC 1049C (Notice ARC 0905C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]  
[Filed ARC 1531C (Notice ARC 1461C, IAB 5/14/14), IAB 7/9/14, effective 8/13/14]  
[Filed ARC 1803C (Notice ARC 1687C, IAB 10/29/14), IAB 12/24/14, effective 1/28/15]  
[Filed ARC 1908C (Notice ARC 1797C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]  
[Filed ARC 2136C (Notice ARC 2023C, IAB 6/10/15), IAB 9/16/15, effective 10/21/15]  
[Filed ARC 2595C (Notice ARC 2516C, IAB 4/27/16), IAB 6/22/16, effective 7/27/16]  
[Filed ARC 3721C (Notice ARC 3593C, IAB 1/31/18), IAB 3/28/18, effective 5/11/18]  
[Filed ARC 4320C (Notice ARC 4198C, IAB 1/2/19), IAB 2/27/19, effective 4/3/19]  
[Filed ARC 4640C (Notice ARC 4520C, IAB 7/3/19), IAB 8/28/19, effective 10/2/19]  
[Filed ARC 5158C (Notice ARC 4996C, IAB 3/25/20), IAB 8/26/20, effective 9/30/20]



## AMUSEMENT PARKS AND RIDES

## CHAPTER 61

## ADMINISTRATION OF IOWA CODE CHAPTER 88A

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/21/98, see 347—Ch 61]

**875—61.1(88A) Scope.** 875—Chapters 61 through 63 do not apply to the following:

**61.1(1)** A water park or water park attraction including, but not limited to, a water slide, wave action pool, and lazy river. This subrule does not apply to an amusement ride that propels patrons using a power source other than gravity even though water is present.

**61.1(2)** A live-animal ride.

**61.1(3)** A vessel inspected pursuant to Iowa Code chapter 462A.

**61.1(4)** An amusement structure in which the patrons navigate on their own power and the patrons do not ride, climb, or walk on a mechanical component.

**61.1(5)** A device that meets all of the following criteria:

- a. Was designed and built to be operated by a coin, card, or token;
- b. Was designed and built to be operated by the patron rather than an attendant;
- c. Operates on self-contained wiring that was installed by the manufacturer;
- d. Operates on less than 120 volts of electrical power; and
- e. Is within or is part of a structure subject to a state or local building code.

**61.1(6)** Playground equipment owned, maintained, and operated by any political subdivision of this state.

**61.1(7)** A concession booth, amusement device, or amusement ride that meets all of the following:

- a. Is owned and operated by a nonprofit organization or school; and
- b. Is located in a building subject to inspection by the state fire marshal or a local government.

**61.1(8)** Nonmechanized physical fitness and playground equipment unless a fee is charged to use the equipment.

**61.1(9)** Physical fitness equipment that does not meet the definition of “amusement device.”

**61.1(10)** A tramway used as a ski lift.

**61.1(11)** A scenic railway operating on standard-gauge rails.

**61.1(12)** A zip line or climbing wall located at a camp or retreat owned or operated by a nonprofit religious, educational or charitable institution or association.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter]

**875—61.2(88A) Definitions.** The definitions in this rule apply to 875—Chapters 61 through 63.

“*Air-supported structure*” means an amusement device that employs a high-strength fabric or film that achieves its strength, shape and stability from internal air pressure provided by a mechanical device such as an air blower or fan.

“*Amusement device*” means a climbing wall utilizing an auto-belay system; a bungee jump as defined in 875—Chapter 63; a device allowing a patron to jump on a trampoline while attached to one or more bungee cords; a dry slide; a mechanical bull; a zip line that does not allow the rider to touch the ground at all times; and an air-supported structure.

“*ANSI*” means the American National Standards Institute.

“*Assistant*” means a paid or volunteer person working under the direct supervision of an attendant or operator.

“*ASTM*” means the ASTM Standards on Amusement Rides and Devices published by ASTM International.

“*Attendant*” means a paid or volunteer person who controls patron restraints or the operation, starting, stopping, or speed of covered equipment.

“*Carnival*” means an enterprise offering amusement or entertainment to the public in, upon, or by means of amusement devices or rides or concession booths.

“*Certificate of noncompliance*” means:

1. A certificate of noncompliance issued by the child support recovery unit, department of human services, pursuant to Iowa Code chapter 252J; or

2. A certificate of noncompliance issued by the centralized collection unit, department of revenue, pursuant to Iowa Code chapter 272D.

*“Commissioner”* means the labor commissioner or the labor commissioner’s authorized designee.

*“Concession booth”* means a structure that is powered by electricity and offers amusements to the public at more than one fair or carnival, or at one fair or carnival for more than seven consecutive days. A structure or enclosure offering only goods, food or beverages, rather than amusements, is not a “concession booth.”

*“Covered equipment”* means an amusement ride, amusement device, concession booth or related electrical equipment that is covered by Iowa Code chapter 88A.

*“Fair”* means an enterprise principally devoted to the exhibition of products of agriculture or industry in connection with the operation of covered equipment.

*“Major breakdown”* means stoppage of operation from any cause that results in damage, failure, or breakage in a stress-bearing part of covered equipment.

*“Major modification”* means any change to the structure of or to an operational characteristic, capacity, classification, or mechanism of covered equipment. “Major modification” includes, but is not limited to, changing the mode of transportation from non-wheeled to a truck or flat-bed mount or changing the mode of assembly or other operational functions from manual to mechanical or hydraulic.

*“NFPA”* means the National Fire Protection Association.

*“Operator”* means a person, or the agent of a person, who owns or controls or has the duty to control the operation of covered equipment at a carnival or fair. “Operator” includes an agency of the state or any of its political subdivisions. “Operator” shall include a person who leases covered equipment and controls or has the duty to control its operation at a carnival or fair.

*“Related electrical equipment”* means a portable generator, blower, or other equipment necessary to the operation of an amusement ride, amusement device, or concession booth.

*“Reportable incident”* means an event described by one or more of the following:

1. Damage, failure or breakage of a stress-bearing part of an amusement ride or amusement device;
2. Cessation of covered equipment for more than 20 minutes with at least one rider aboard;
3. An occurrence that nearly resulted in personal injury; or
4. An occurrence that caused the operator to cease operations unexpectedly to avoid an injury or illness.

*“Rope lay”* means the length along the rope in which one strand makes a complete revolution around the rope.

*“Walkway”* means a public passage through a carnival, fair, or park.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—61.3(88A) Owner and operator requirements.** No person shall operate covered equipment at a carnival or fair unless the person holds a current operating permit and the covered equipment has passed an Iowa inspection.

**61.3(1) Operating permit.** No later than May 1 and at least 30 days before operation begins each calendar year, the operator of covered equipment shall apply to the commissioner for an operating permit. Applications may be submitted in November for continuous operations. Application shall be made on a form provided by the commissioner. Each of the following shall be submitted with the completed operating permit application:

- a. The applicable fee;
- b. A certificate of insurance issued by an insurance company authorized to do business in Iowa. The certificate of insurance shall:

- (1) Certify a policy in the minimum amount of \$1 million for bodily injury, death, or property damage in any one occurrence;

- (2) List the specific pieces of equipment that are covered and, if applicable, those that are not covered; and

- (3) Include “Division of Labor Services—Amusements” as a certificate holder;
  - c. The operator’s itinerary identifying the covered equipment to be operated and the dates and locations where each will be operated;
  - d. General design criteria, safety factors, materials utilized, and stress analysis unless the amusement ride or amusement device was granted an Iowa amusement inspection sticker during the previous calendar year;
  - e. Certification of compliance with applicable training and maintenance requirements;
  - f. With an application submitted after May 1, proof that the applicant could not have reasonably complied with the May 1 deadline and proof that the application was filed immediately after need for the permit was known;
  - g. Separately for each bungee jump:
    - (1) A site operating manual;
    - (2) A report which is prepared and sealed by a professional engineer who is licensed in Iowa and which certifies that the design and construction of the equipment and structure are suitable for the intended use and conform to Iowa law, recognized engineering practices, procedures, standards and specifications;
  - (3) Site plan drawings depicting the preparation area, the jump space, the landing area, the recovery area and other features to be included in the approved operating site;
  - (4) Specifications of equipment and structures; and
  - (5) Depictions of the location, specifications, dimensions, and type of air bag, pool or body of water where the jumper will land.

**61.3(2) *Changes to information submitted with application.*** The operator shall immediately notify the commissioner of any changes to the operator’s itinerary. The operator shall promptly notify the commissioner of other changes to information provided with the operating permit application.

**61.3(3) *Leases.*** The requirements of this subrule apply when covered equipment is leased for use at a fair or carnival.

a. The owner shall notify the commissioner within 48 hours of leasing the covered equipment. The notification shall include the name, address, and contact information for the lessee and lessor, a description of the covered equipment, and the dates and location of its intended operation.

b. The lessor shall give the lessee a copy of the manual for the leased covered equipment and shall train the lessee or the lessee’s designated representatives on the use of the equipment.

c. The lessee shall obtain an operating permit.

**61.3(4) *Personal injuries and deaths.***

a. The operator shall immediately report by telephone any accident that results in death or medical care beyond first aid.

b. Within 48 hours after an operator is notified of a claim or report to the operator’s insurance provider, the operator shall submit a duplicate copy of the report or claim to the commissioner.

c. The commissioner may require that the scene of an accident be secured and not disturbed to any greater extent than necessary for removal of the deceased or injured person. If covered equipment is removed from service by the commissioner, the covered equipment shall be returned to service only upon the commissioner’s authorization.

**61.3(5) *Major breakdown report.*** The operator shall report a major breakdown of covered equipment to the commissioner immediately and provide a detailed report in writing within 48 hours. The commissioner may order the covered equipment to be withheld from operation, and in such case, the commissioner shall conduct an immediate investigation. The covered equipment shall be released for repair and operation only after the commissioner’s investigation is complete.

**61.3(6) *Advance notice of major modification.*** The operator shall notify the commissioner in writing at least ten days prior to a major modification. If requested by the commissioner, the operator shall provide plans, diagrams, and ride analysis documentation consistent with ASTM F2291-15.

**61.3(7) *Technical data.*** If requested by the commissioner, the operator shall provide an English language version of the following:

*a.* Data concerning constant, reversible, or eccentric forces generated by acceleration, deceleration, wind, centrifugal action, or inertia.

*b.* Stress analysis and other data pertinent to the structural materials, design, structure, factors of safety or performance characteristics.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 3685C, IAB 3/14/18, effective 4/18/18; ARC 5022C, IAB 4/8/20, effective 5/13/20]

**875—61.4(88A) Inspections.** Pursuant to Iowa Code chapter 88A, covered equipment must pass an inspection at least annually. Inspections will be performed according to the rules set forth and standards adopted in 875—Chapters 61 to 63.

**61.4(1) *Inspection types.*** In addition to the inspections listed below, an inspection may be conducted by the commissioner at any time. The fee schedule for annual inspections set forth in Iowa Code section 88A.4 shall apply to all inspections performed by division of labor services inspectors. No person shall operate covered equipment at a fair or carnival unless the covered equipment has passed an inspection in the current calendar year.

*a. Annual inspection by owner.* At the discretion of the commissioner, the owner of an air-supported structure may be designated by the commissioner to perform the annual inspection of the owner's air-supported structure, blower, and related electrical equipment. An owner designated pursuant to this paragraph shall perform the inspection according to applicable standards. The owner shall submit in the format required by the commissioner an affidavit attesting to the performance of the inspection, correction of code violations, and other required information. A designation pursuant to this paragraph shall terminate on December 31 of the year of issuance.

*b. Annual inspection by a division of labor services inspector.* Unless an inspection is waived pursuant to Iowa Code section 88A.13, or the inspection is performed by the owner pursuant to paragraph 61.4(1) "a," a division of labor services inspector shall inspect covered equipment prior to operation.

*c. Major modification inspection.* After covered equipment has undergone a major modification, the covered equipment must pass an inspection by a division of labor inspector before it is put back into use.

**61.4(2) *Safety order.*** If the division of labor services inspector finds a code violation, the inspector will issue a safety order requiring that the condition be corrected. The deadline for correction of the code violation shall be set forth in the safety order. If the inspector finds one or more code violations pertaining to more than one-half of the seating capacity of an amusement ride, the amusement ride shall not be operated until the violations are corrected. If code violations pertain to one-half or less of the seating capacity of an amusement ride, the amusement ride may be shut down at the discretion of the inspector.

**61.4(3) *Cessation order.*** If the inspector identifies covered equipment that is hazardous or unsafe, the inspector shall issue a cessation order. The commissioner shall establish that the code violation is corrected before operation of the covered equipment is resumed.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 3685C, IAB 3/14/18, effective 4/18/18]

**875—61.5(88A) Amusement inspection sticker.** Covered equipment shall not be operated without a current sticker.

**61.5(1)** After covered equipment has passed an annual inspection by the division of labor services inspector, the division of labor services inspector shall affix an amusement inspection sticker to a basic part of the covered equipment in such a manner as to be readily accessible by the inspector.

**61.5(2)** After the commissioner receives satisfactory proof of inspection from an owner designated by the labor commissioner pursuant to paragraph 61.4(1) "a," the commissioner shall mail the sticker to the owner. The owner shall properly affix the sticker to a basic part of the air-supported structure or blower before operation.

**61.5(3)** After covered equipment passes a major-modification inspection, a new amusement inspection sticker will be issued.

**61.5(4)** Before covered equipment is sold, the seller shall remove the amusement inspection sticker. If a current amusement inspection sticker is no longer legible, the operator may request a replacement sticker.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter]

**875—61.6(88A,252J,272D) Termination, denial, suspension, or revocation of an operating permit.**

**61.6(1)** All active operating permits shall terminate automatically on December 31 of the year of issuance.

**61.6(2)** The commissioner may suspend or revoke an operating permit for any of the following reasons:

- a. Negligence in the operation of covered equipment;
- b. Repeated failure to perform or document proper daily inspections;
- c. Misrepresentation of material information required as a part of the operating permit application package;
- d. Failure to comply with a safety order or cessation order issued by the commissioner;
- e. Operation of covered equipment in disregard of public health, safety and welfare;
- f. Termination of the required insurance coverage;
- g. Failure to pay a liquidated debt owed to the commissioner;
- h. Receipt by the commissioner of a certificate of noncompliance;
- i. Failure of an operator to comply with the proper procedures;
- j. Failure of an operator to provide an adequate number of properly trained and qualified assistants and attendants; or
- k. Submission of a false affidavit of annual inspection by the owner of an air-supported structure.

**61.6(3)** The commissioner may deny an application for an operating permit if the application packet is inadequate or for any reason set forth as grounds for suspension or revocation of an operating permit. [ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—61.7(17A,88A,252J,272D) Procedures for revocation, suspension, or denial of an operating permit or amusement inspection sticker.** The procedures set forth in this rule govern the revocation, suspension or denial of an operating permit or amusement inspection sticker.

**61.7(1)** If the commissioner initiates revocation, suspension or denial due to the receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J or 272D shall apply.

**61.7(2)** In the event that immediate action is required due to imminent danger to the public health, safety or welfare, the following procedures shall apply:

- a. The commissioner shall prepare a safety order describing the hazardous condition and shall give the operator, or the operator's representative on site, a copy of the safety order.
- b. The commissioner shall remove the amusement inspection sticker or stickers from covered equipment as necessary to protect the public health, safety or welfare.
- c. The commissioner shall proceed as quickly as feasible to give the operator an opportunity for a hearing as set forth in subrule 61.7(3).

**61.7(3)** In all other cases, the following procedures shall apply:

- a. The commissioner shall serve a notice by restricted certified mail to the address listed on the operating permit application or by other service as permitted by Iowa Code chapter 17A.
- b. The operator shall have 20 days to file a written notice of contest with the commissioner. If the operator does not file a written notice of contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.
- c. The hearing procedures in 875—Chapter 1 shall govern.
- d. Within five business days of final agency action revoking or suspending an operating permit, the operator shall forfeit the operating permit to the commissioner.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—61.8(88A) Payments.** All fees are nonrefundable. Cash is not accepted. Based on reasonable justification, the commissioner may notify an individual operator that the operator's check will not be accepted.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 3685C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement Iowa Code chapters 17A, 88A, 252J, and 272D.

[Filed 2/21/73, amended 12/20/73, 4/8/75, 6/19/75]

[Filed 3/5/76, Notice 1/26/76—published 3/22/76, effective 4/30/76]

[Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]

[Filed emergency 8/30/88—published 9/21/88, effective 8/30/88]

[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]

[Filed 4/16/07, Notice 2/28/07—published 5/9/07, effective 6/13/07]

[Filed ARC 8395B (Notice ARC 8241B, IAB 10/21/09), IAB 12/16/09, effective 1/20/10]

[Filed ARC 2428C (Notice ARC 2354C, IAB 1/6/16), IAB 3/2/16, effective 4/6/16]<sup>1</sup>

[Filed ARC 3685C (Notice ARC 3539C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

[Filed ARC 5022C (Notice ARC 4894C, IAB 2/12/20), IAB 4/8/20, effective 5/13/20]

[Filed ARC 5159C (Notice ARC 4940C, IAB 2/26/20), IAB 8/26/20, effective 9/30/20]

<sup>1</sup> April 6, 2016, effective date of the rescission of former Chapter 61 and the adoption of new Chapter 61 herein [ARC 2428C] delayed 70 days by the Administrative Rules Review Committee at its meeting held March 4, 2016; delay lifted at the meeting held April 8, 2016.



CHAPTER 71  
ADMINISTRATION OF THE CONVEYANCE SAFETY PROGRAM

**875—71.1(89A) Definitions.** The definitions contained in this rule shall apply to 875—Chapters 71, 72, and 73.

*“Acceptance checklist”* means a checklist available on the website of the division of labor services that includes a list of major systems and components of conveyances.

*“AECO”* means an elevator/escalator certification organization accredited pursuant to ASME A17.7.

*“Approved”* means approved by the division.

*“CCD”* means code compliance documentation as described in ASME A17.7, Section 2.10.

*“CEI”* means a person who is a certified elevator inspector or certified elevator inspector supervisor and who received the certification from a certifying organization that holds a valid document of accreditation issued by an accreditation body in accordance with ANSI/ISO/IEC 17024.

*“Center of the elevator path”* means a vertical line through the center point of an elevator car top beginning 2 feet below the lower landing and ending 10 feet above the highest landing of an elevator.

*“Control”* means the system governing the starting, stopping, direction of motion, acceleration, speed and deceleration of the moving member.

*“Conveyance”* means any elevator, escalator, material lift elevator installed on or after August 10, 2016, dumbwaiter, wind tower lift, CPH, or other equipment governed by Iowa Code chapter 89A.

*“CPH”* means a construction personnel hoist.

*“CPH jump”* means the addition or removal of mast or tower allowing a change in the hoist service elevation of a CPH.

*“Division”* means the labor services division of the workforce development department.

*“Elevator”* means a hoisting and lowering mechanism equipped with a car or platform which moves in guides in a substantially vertical direction and which serves two or more floors of a building or structure. “Elevator” does not include a CPH.

*“Elevator mechanic”* means a person who meets the standard for “elevator personnel” found in ASME A17.1.

*“Hoistway-unit system”* means a series of hoistway-door interlocks, hoistway-door electric contacts or hoistway-door combination mechanical locks and electric contacts, or a combination thereof, the function of which is to prevent operation of the driving machine by the normal operating device unless all hoistway doors are in the closed position and, if required, locked.

*“Wind tower lift”* means a conveyance designed and utilized solely for movement of trained and authorized people and small loads in wind towers built for the production of electricity.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 1159C, IAB 10/30/13, effective 12/4/13; ARC 2603C, IAB 7/6/16, effective 8/10/16; ARC 4212C, IAB 1/2/19, effective 3/1/19]

**875—71.2(89A) Registration of conveyances.** The owner or authorized agent of each operable conveyance not previously registered shall register the conveyance. An application to install a new conveyance shall constitute registration. All registrations shall be submitted to the commissioner on forms available from the division of labor services and shall include all information requested by the labor commissioner.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.3(89A) State identification number.** The commissioner shall assign an identification number to each conveyance that shall be stamped on a metal tag permanently attached to the controller, to the electrical disconnecting switch, or in a wind tower lift cage.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.4(89A) Responsibility for obtaining permits.** The procuring of all permits and the payment of all fees required by this chapter shall be the responsibility of the owner. Failure to obtain the appropriate permit prior to installation, alteration or operation may, at the discretion of the labor commissioner,

result in a referral to the attorney general for prosecution of criminal penalties as described in Iowa Code section 89A.17.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.5(89A) Installation permits.**

**71.5(1)** Installation shall not begin until an installation permit has been issued by the division. A separate installation permit shall be issued for each conveyance, except that a single installation permit shall cover all identical wind tower lifts installed as the result of one construction contract in identical wind towers in a single wind farm.

**71.5(2)** Application for an installation permit shall be accompanied by the fee specified in rule 875—71.16(89A), shall be in the format required by the labor commissioner, and shall include the following, as applicable:

- a. Sectional plan of car and hoistway.
- b. Sectional plan of machine room.
- c. Sectional elevation of hoistway and machine room including the pit, bottom and top clearance of car and counterweights.
- d. Size and weight of rails and guide rail bracket spacing.
- e. The estimated maximum vertical forces on the guide rails on application of the safety device.
- f. In the case of freight elevators for class B or class C loading, the horizontal forces on the guide rail faces during loading and unloading and the estimated maximum horizontal forces in a post-wise direction on the guide rail faces on the application of the safety device.
- g. The size and weight per foot of any rail reinforcements where rail reinforcements are provided.
- h. Job specifications.
- i. For a conveyance covered by ASME A17.7, a complete copy of the CCD with attachments and a complete copy of the Certificate of Conformance with attachments as described by ASME A17.7, Appendix I, Section 4.5.
- j. For a CPH, the number of CPH jumps planned, the planned dates for each CPH jump, and the change in the number of floors anticipated with each CPH jump.

**71.5(3)** A CPH installation permit issued in response to an application submitted in full compliance with this subrule permits each planned CPH jump. Each CPH jump shall be considered an alteration. The fee submitted for a CPH installation permit shall be the total of the CPH installation permit fee as set forth in subrule 71.16(3) and the CPH alteration permit fee as set forth in subrule 71.16(4).

**71.5(4)** Issuance of an installation permit shall not be construed as a waiver or variance of any requirement of law.

**71.5(5)** The installation permit or a copy of the installation permit shall be conspicuously posted at the worksite. All the wind towers covered by a single installation permit shall be considered a single worksite, and posting one copy of the installation permit at the construction project office shall be sufficient compliance with this subrule.

**71.5(6)** Except as described in paragraphs 71.5(6) “a” and “b,” the installation permit shall expire upon the earlier of the completion of the installation as described in the permit application or one year after issuance.

- a. For a CPH, the installation permit shall expire upon completion of the last CPH jump.
- b. For any conveyance, during the tenth month after issuance, and upon submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension may be granted at the discretion of the labor commissioner.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10]

**875—71.6(89A) Construction permits.** A construction permit authorizes the temporary, limited use of an elevator for purposes relating to construction or demolition.

**71.6(1)** Use of the elevator shall not begin until a construction permit has been issued by the division.

**71.6(2)** Application for a construction permit shall be in the format required by the labor commissioner and must include all the information requested by the labor commissioner and the fee specified by this chapter.

**71.6(3)** Upon submission of the completed application and fee, a state inspector shall be scheduled to inspect the elevator. Construction permits shall be issued only if the following criteria are met:

*a.* The elevator has been successfully tested pursuant to the requirements of ASME A17.1, Section 8.11.5.13; and

*b.* The applicable requirements of ASME A17.1, Section 5.10, are met.

**71.6(4)** The construction permit or a copy of the construction permit shall be posted conspicuously in a protective sleeve in the elevator car.

**71.6(5)** The construction permit shall expire 120 days after issuance. However, between 90 and 110 days after issuance and upon submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension of up to 90 days may be granted at the discretion of the labor commissioner.

**71.6(6)** Elevators with a construction permit but without an operating permit shall not be accessible to the general public.

**71.6(7)** Failure to comply with these provisions may result in the revocation of the construction permit.

**71.6(8)** An operating permit shall not be issued before construction and an acceptance inspection are complete.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

#### **875—71.7(89A) Operating permits.**

**71.7(1)** Operation of equipment covered by this chapter without a current operating permit is prohibited, except as authorized by rules 875—71.6(89A), 875—71.8(89A), and 875—71.20(89A). If operation of a conveyance is prohibited under this rule, the labor commissioner may post notice on the conveyance that it is not to be used. The conveyance may be returned to service only after an operating permit for the conveyance has been issued or reissued.

**71.7(2)** Operating permits shall not be issued prior to successful completion of an inspection pursuant to rule 875—71.11(89A) and payment of all permit and inspection fees owed to the division.

**71.7(3)** Current operating permits or copies of current operating permits shall be conspicuously displayed as follows:

*a.* The operating permit for an elevator or CPH shall be posted in the car.

*b.* The operating permit for an escalator, dumbwaiter, wind tower lift, moving walk, or wheelchair lift shall be posted on or near the subject conveyance.

**71.7(4)** An operating permit shall expire 60 days after the first permit renewal inspection following the issuance of the operating permit, unless an earlier date is dictated by this rule.

**71.7(5)** An operating permit is automatically suspended when an alteration begins. The operating permit automatically resumes when the elevator passes an inspection pursuant to rule 875—71.11(89A).

**71.7(6)** An operating permit is automatically terminated when an imminent danger notice is posted on the conveyance.

**71.7(7)** Notwithstanding other provisions of this rule, at the discretion of the labor commissioner, a temporary operating permit may be issued for up to 30 days provided the inspection has been completed and no code violations were identified. Issuance of a temporary operating permit does not extend the expiration date of the conveyance's operating permit.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 0318C, IAB 9/5/12, effective 10/10/12; ARC 0574C, IAB 2/6/13, effective 3/13/13; ARC 0685C, IAB 4/17/13, effective 5/22/13]

**875—71.8(89A) Controller upgrade permits.** A controller upgrade permit may be issued to allow operation of an elevator while work to upgrade controls requires deactivation of the Phase I recall initiated by smoke sensing devices. Each elevator to be altered requires a separate controller upgrade permit. The duration of a controller upgrade permit shall not exceed 90 days. Each elevator in the group shall pass inspection pursuant to rule 875—71.11(89A) prior to being placed back into service.

**71.8(1)** A controller upgrade permit shall not be issued unless each of the following conditions is met:

*a.* Two or more elevators share a lobby at the level of the recall floor.

- b. The project includes the installation of new elevator controllers in all of the elevators in the group.
- c. Phase I fire recall initiated by a key-operated switch and all other controls shall be properly functioning for each elevator available for use.
- d. There is a current alteration permit for the project.
- e. A complete application for the controller upgrade permit and the fee established by this chapter have been submitted and accepted.

**71.8(2)** A controller upgrade permit shall not be construed to waive or excuse compliance with the requirements of any other governmental entity, including the department of public safety.

**71.8(3)** Upon the submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension of the permit for up to 60 days may be granted.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

### **875—71.9(89A) Alteration permits.**

**71.9(1)** Alteration shall not begin until an alteration permit has been issued by the division.

**71.9(2)** Application for an alteration permit shall be in the format required by the labor commissioner and shall include drawings and specifications of all planned changes and the fee specified by rule 875—71.16(89A).

**71.9(3)** Issuance of an alteration permit shall not be construed as a waiver or variance of any requirement of law.

**71.9(4)** The alteration permit or a copy of the alteration permit shall be conspicuously posted at the worksite.

**71.9(5)** If a complete installation permit application was submitted for a CPH pursuant to subrule 71.5(3), at least seven days' advance notice of each CPH jump shall be provided to the labor commissioner.

**71.9(6)** The alteration permit shall expire upon the earlier of the completion of the alteration as described in the permit application or one year after issuance. However, during the tenth month after issuance and upon submission to the labor commissioner of the fee set forth in this chapter, sufficient justification, and other required information, the labor commissioner may grant an extension of the alteration permit.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 2333C, IAB 1/6/16, effective 2/10/16]

### **875—71.10(89A) Alterations.**

**71.10(1)** Alterations or changes shall comply with rule 875—72.13(89A) or rule 875—73.8(89A), as applicable.

**71.10(2)** A conveyance that is relocated shall be brought into compliance with all codes that are applicable at the time of relocation.

**71.10(3)** Alterations of conveyances other than escalators and elevators shall require that the entire conveyance be brought into compliance with the current code.

**71.10(4)** Work required by ASME A17.3 (2011) qualifies as normal maintenance and does not require an alteration permit except for work performed to comply with ASME A17.3 (2011) 2.3.3, 3.4.4.1(a), 3.4.4.2, 3.5.3, 3.5.5(a) and (b), 3.5.7, 3.6.1, 3.6.2, 3.8.1(a), 3.8.3(a), 3.10.1, 3.10.4(b) through (g), 3.10.4(i) through (k), 3.10.4(m), 3.10.4(r), 3.10.4(w), 3.10.7, 3.10.9, 3.10.10, 4.4.2, 4.4.3, and 4.7.3. [ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 2396C, IAB 2/17/16, effective 3/23/16; ARC 4376C, IAB 3/27/19, effective 5/1/19]

**875—71.11(89A) Inspections.** Pursuant to Iowa Code section 89A.12, inspections by the labor commissioner's designee shall be permitted at reasonable times with or without prior notice.

**71.11(1) Scope of inspections.**

a. *Comprehensive.* Periodic inspections shall be comprehensive. Elevators being transferred from construction permits to operating permits, previously dormant conveyances being returned to service, relocated conveyances, and new conveyances shall be inspected in their entirety prior to operation.

*b. Limited.* The scope of an inspection after an alteration shall be determined by rule 875—72.13(89A) or 875—73.8(89A), as applicable. However, if the inspector notices a safety hazard in plain view outside the altered components, or if the periodic inspection is due, the entire conveyance shall be inspected.

**71.11(2) *When inspections will occur.*** When the timing of two different types of inspection on a single conveyance coincide, a state inspector may perform both inspections in one visit.

*a. Periodic inspections.*

(1) Each construction elevator and CPH shall be inspected at intervals not to exceed three months. All other periodic conveyance inspections by state inspectors shall be conducted annually unless the labor commissioner determines resources do not allow annual inspections. If the labor commissioner determines quarterly inspections of construction elevators and CPHs and annual inspections of other state-inspected conveyances are not feasible due to insufficient resources, the labor commissioner shall determine the inspection schedule.

(2) Conveyance inspections by special inspectors shall be conducted at least annually.

(3) The inspector shall arrange to perform the periodic inspection of a broadcast tower elevator when the maintenance company is on site to perform the periodic tests. If the inspection is to be performed by employees of the commissioner, the inspection shall occur during the division's normal business hours, unless otherwise agreed to by the commissioner pursuant to subrule 71.16(11).

*b. Acceptance inspections.* A CPH shall be inspected pursuant to the schedule in ANSI A10.4 – 2007, Chapter 26. For all other conveyances, an acceptance inspection shall occur:

(1) After each relocation,

(2) After each alteration,

(3) For a new installation, not less than two business days after a completed acceptance checklist is submitted by the conveyance installation company,

(4) Before an elevator subject to a construction permit receives an operating permit, and

(5) Before a previously dormant conveyance is returned to service.

*c. Other inspections.* Inspections may be made when the commissioner reasonably believes that a conveyance is not in compliance with the rules. Accidents, complaints, or requests for consultative inspections may result in inspections by the labor commissioner's designee.

**71.11(3) *Who may perform inspections.***

*a.* The labor commissioner's designee shall inspect altered conveyances, construction elevators, CPHs, previously dormant conveyances being returned to service, relocated conveyances, and new conveyances.

*b.* Except as noted in 71.11(3) "c," annual inspections may be performed by state inspectors or special inspectors authorized by the labor commissioner pursuant to rule 875—71.12(89A).

*c.* An inspection report by a special inspector shall not be accepted as the required, annual inspection if the conveyance is under contract for maintenance, installation or alteration by the special inspector or the special inspector's employer, or if the property is owned or leased by the special inspector or the special inspector's employer.

**71.11(4) *Inspection standards.*** Inspections shall be performed in accordance with applicable safety codes or documents such as:

*a.* CCD;

*b.* ASME A17.1, Sections 8.10 and 8.11, except Section 8.11.1.1;

*c.* ANSI A10.4-2007; or

*d.* ASME A18.1.

**71.11(5) *Inspection reports.***

*a.* All inspectors shall file inspection reports on forms approved by the commissioner within 30 days from the date of inspection and shall provide owners of conveyances with copies of completed inspection reports. The inspection report must separately list each unsafe condition and the applicable, specific code citation. Up to 30 days shall be allowed for correction of the unsafe conditions.

b. The owner may file a petition for reconsideration of an inspection report pursuant to 875—Chapter 69. The timely and proper filing of a petition for reconsideration extends the deadline for correction of the hazards that are subject to the petition for reconsideration.

**71.11(6) Extension of time.** The owner may petition the commissioner for up to 60 additional days to make the necessary corrections. The time frames set forth in subrule 71.11(7) may be adjusted by the labor commissioner as necessary to accommodate an extension of time.

**71.11(7) Correction of unsafe conditions.** In the absence of a determination on reconsideration or appeal that correction of hazards is not required, all unsafe conditions identified in the inspection report shall be corrected. The labor commissioner shall verify correction of all unsafe conditions identified in the inspection report by sending a state inspector to reinspect the conveyance for the fee set forth in rule 875—71.16(89A), or by reviewing appropriate documentation such as a photograph, invoice, other verifiable document, or subsequent inspection report. The time frames set forth in this subrule may be accelerated at the request of the owner.

a. Promptly upon receipt of an inspection report listing unsafe conditions, the labor commissioner will send to the owner and the special inspector, if any, an abatement order. A copy of the inspection report shall be attached to the abatement order. Unless a special inspector conducted the inspection, the order may specify a period that ends no more than 45 days after the inspection during which the owner may submit written evidence that the unsafe conditions have been corrected. The abatement order shall:

- (1) Identify the equipment.
- (2) Demand that the unsafe conditions be corrected within the period set forth in the inspection report.
- (3) Set forth the consequences of failure to comply.

b. After the period specified on the inspection report has passed, the labor commissioner may cause a state inspector to verify correction of all unsafe conditions. If reinspection reveals no significant progress toward correcting the unsafe conditions, or the remaining unsafe conditions create significant safety concerns, the labor commissioner may serve a notice of intent to suspend, deny or revoke the operating permit.

c. The labor commissioner may issue an operating permit after receipt of the appropriate fee and verification that each unsafe condition identified in the inspection report has been corrected.

d. If written proof of correction was requested in the abatement order, but adequate proof was not received by the deadline set forth in the abatement order, the labor commissioner may send a second abatement order or cause a state inspector to inspect the conveyance. If the labor commissioner elects to send a second abatement order, it shall notify the owner that, if written proof of abatement is not received within 20 days, a state inspector may be sent to the site. Copies of the abatement order and the inspection report shall be attached to the second abatement order.

e. If a special inspector conducted the inspection, more than 45 days have passed since the deadline for correction of hazards, and an inspection report indicating the hazards are corrected has not been filed, the labor commissioner may contact the special inspector, send a second abatement order to the owner, or send a state inspector to inspect the conveyance. Copies of the abatement order and the inspection report shall be attached to a second abatement order.

f. If an inspection as described in paragraph 71.11(7) “d” or “e” reveals no significant progress toward correcting the unsafe conditions, and the remaining unsafe conditions create no significant safety concerns, the labor commissioner may extend the time for abatement of the unsafe conditions an additional 10 days or may serve a notice of intent to suspend, deny or revoke the operating permit. The labor commissioner may also post a notice prohibiting use of the conveyance pending abatement of the unsafe conditions listed in the inspection report.

g. Procedures for appeal of a notice of intent to suspend, deny or revoke an operating permit are set forth in 875—Chapter 69.

**71.11(8) Imminent danger.** If the labor commissioner determines that continued operation of a conveyance pending correction of unsafe conditions creates an imminent danger, the labor commissioner shall post notice on the conveyance that it is not to be used pending repairs. Use of a conveyance contrary to posted notice by the labor commissioner may result in additional legal proceedings pursuant

to Iowa Code section 89A.10(3) or 89A.18. The conveyance may be returned to service only after the imminent danger has been corrected and the conveyance has passed a comprehensive inspection.

**71.11(9) *Interference prohibited.*** No person shall interfere with, delay or impede an inspector employed by the state during an inspection.

**71.11(10) *Escalator inspections.*** The owner shall arrange for an escalator mechanic to be on site to assist with the inspection. The inspector shall work with the owner to arrange an inspection time.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 1971C, IAB 4/29/15, effective 6/3/15; ARC 2607C, IAB 7/6/16, effective 8/10/16; ARC 3742C, IAB 4/11/18, effective 5/16/18; ARC 3856C, IAB 6/20/18, effective 8/1/18]

**875—71.12(89A,252J,272D) Special inspector commissions.**

**71.12(1) *Definition.*** As used in this rule, “certificate of noncompliance” means:

a. A certificate of noncompliance issued by the child support recovery unit, department of human services, pursuant to Iowa Code chapter 252J; or

b. A certificate of noncompliance issued by the centralized collection unit of the department of revenue pursuant to Iowa Code chapter 272D.

**71.12(2) *Qualifications.***

a. Each applicant must possess a high school diploma or general equivalency degree.

b. Each applicant shall have at least three years of full-time work experience in the construction, installation, repair or inspection of conveyances.

c. Each applicant shall be a CEI.

d. Each applicant shall satisfactorily pass a division of labor services examination on Iowa procedures, Iowa policies, and all safety standards adopted by reference.

e. Each applicant shall submit proof of insurance coverage insuring the applicant against liability for injury or death for any act or omission on the part of the applicant. The insurance policy shall be in an amount of not less than \$1,000,000 for bodily injury to or death of one person in any one accident, and in an amount of not less than \$5,000,000 for bodily injury to or death of two or more persons in any one accident, and in an amount of not less than \$100,000 for damage to or destruction of property in any one accident. The insurance coverage of the special inspector’s employer shall be considered to comply with this requirement if the coverage provides equivalent coverage for each special inspector.

**71.12(3) *Application.*** An applicant for a commission shall complete, sign, and submit to the division the form provided by the division with the required fee. The applicant shall include with the application proof that the applicant is a CEI.

**71.12(4) *Expiration.*** The commission expires when the commission is suspended or revoked by the labor commissioner or one year from issuance, whichever occurs earlier.

**71.12(5) *Changes.*** The special inspector shall notify the division at the time any of the information on the form or attachments changes.

**71.12(6) *Denials.*** The labor commissioner may refuse to issue or renew a special inspector’s commission for failure of the applicant to complete an application package, if the applicant is not a CEI, or for any reason listed in subrules 71.12(8) to 71.12(10).

**71.12(7) *Investigations.*** The labor commissioner may investigate for any reasonable cause related to special inspectors or special inspector applicants. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice at the times and in the places the labor commissioner directs. The labor commissioner may notify the organization that certified the special inspector as a CEI of the findings of an investigation.

**71.12(8) *Reasons for probation.*** The labor commissioner may issue a notice of commission probation when an investigation reasonably reveals that the special inspector filed inaccurate reports.

**71.12(9) *Reasons for suspension.*** The labor commissioner may issue a notice of commission suspension when an investigation reasonably reveals any of the following:

a. The special inspector failed to submit and report inspections on a timely basis;

b. The special inspector abused the special inspector’s authority;

c. The special inspector misrepresented self as a state inspector or a state employee;

d. The special inspector used commission authority for inappropriate personal gain;

- e.* The special inspector failed to follow the division's rules for inspection of object repairs, alterations, construction, installation, or in-service inspection;
- f.* The special inspector committed numerous violations as described in subrule 71.12(8);
- g.* The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;
- h.* The special inspector is no longer a CEI;
- i.* The division received a certificate of noncompliance; or
- j.* The special inspector failed to take appropriate disciplinary actions against a subordinate special inspector who has committed repeated acts or omissions listed in paragraphs 71.12(9) "a" to "h."

**71.12(10) *Reasons for revocation.*** The labor commissioner may issue a notice of revocation of a special inspector's commission when an investigation reveals any of the following:

- a.* The special inspector filed a misleading, false or fraudulent report;
- b.* The special inspector failed to perform a required inspection;
- c.* The special inspector failed to file a report or filed a report which was not in accordance with the provisions of applicable standards;
- d.* The special inspector committed repeated violations as described in subrule 71.12(9);
- e.* The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;
- f.* The special inspector instructed, ordered, or otherwise encouraged a subordinate special inspector to perform the acts or omissions listed in paragraphs 71.12(10) "a" to "e";
- g.* The special inspector is no longer a CEI; or
- h.* The division received a certificate of noncompliance.

**71.12(11) *Procedures.*** The following procedures shall apply except in the event of revocation or suspension due to receipt of a certificate of noncompliance. In instances involving receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J or 272D shall apply.

*a. Notice of actions.* The labor commissioner shall serve a notice on the special inspector by certified mail to an address listed on the commission application form or by other service as permitted by Iowa Code chapter 17A.

*b. Contested cases.* The special inspector shall have 20 days to file a written notice of contest with the labor commissioner. If the special inspector does not file a written contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.

*c. Hearing procedures.* The hearing procedures in 875—Chapter 1 shall govern.

*d. Emergency suspension.* Pursuant to Iowa Code section 17A.18A, if the labor commissioner finds that the public health, safety or welfare imperatively requires emergency action because a special inspector failed to comply with applicable laws or rules, the special inspector's commission may be summarily suspended.

*e. Probation period.* A special inspector may be placed on probation for a period not to exceed one year for each incident causing probation.

*f. Suspension period.* A special inspector's commission may be suspended up to five years for each incident causing a suspension.

*g. Revocation period.* A special inspector's commission that has been revoked shall not be reinstated for five years.

*h. Concurrent actions.* Multiple actions may proceed at the same time against any special inspector.

*i. Revoked or suspended commissions.* Within five business days of final agency action revoking or suspending a special inspector commission, the special inspector shall surrender the special inspector's commission card to the labor commissioner. The labor commissioner may notify the special inspector's employer and the organization that certified the special inspector as a CEI of a revocation or suspension. [ARC 7841B, IAB 6/17/09, effective 7/22/09; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—71.13(89A) State employees.** Rescinded ARC 1971C, IAB 4/29/15, effective 6/3/15.



**875—71.14(89A) Safety tests.** Only safety test reports submitted on approved forms from elevator mechanics who are employed by authorized companies shall be considered to meet the requirements of this rule. The alternative test methods set forth at ASME A17.1, Rule 8.6.11.10, shall not be allowed as a substitute for a full-load safety test.

**71.14(1) *When safety tests will be performed.***

- a. Safety tests shall be performed on new and altered installations before they are placed in service.
- b. Category 1 safety tests of wind turbine tower elevators shall be conducted after two years of operation, and category 5 safety tests of wind turbine tower elevators shall be performed after ten years of operation. Safety tests shall be made on all other conveyances pursuant to the schedules and procedures set forth in:

- (1) The maintenance control plan for wind tower lifts exempted from ASME A17.1 by rule 875—72.12(89A);

- (2) The CCD for conveyances covered by ASME A17.7-2007/CSA B44-07;

- (3) The columns pertaining to “periodic tests” in Table N-1 in the edition of ASME A17.1 currently adopted for new conveyances at rule 875—72.1(89A);

- (4) ASME A18.1(2003), Part 10; or

- (5) ANSI A10.4-2007, Section 26.4.

**71.14(2) *How safety tests will be reported.*** Within 30 days after completion of a safety test, the elevator mechanic shall file with the labor commissioner a report on an approved form and shall provide a copy of the form to the owner and to the witness, if applicable.

**71.14(3) *How safety tests will be recorded.*** The elevator mechanic shall attach a tag showing the date of the test, the elevator mechanic’s name, and the type of test performed.

- a. On electric traction elevators, the elevator mechanic shall attach the tag to the safety-releasing carrier.

- b. On hydraulic elevators, the elevator mechanic shall attach the tag to the disconnecting switch or the controller.

- c. On wheelchair lifts, the elevator mechanic shall attach the tag to the disconnecting switch.

- d. On other conveyances covered by these rules, the commissioner’s designee witnessing the acceptance safety test shall indicate the proper location of the tag. Subsequent test tags shall be attached in the same location.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0168C, IAB 6/13/12, effective 7/18/12; ARC 1766C, IAB 12/10/14, effective 1/14/15; ARC 3742C, IAB 4/11/18, effective 5/16/18]

**875—71.15(89A) Authorized companies.**

**71.15(1)** Each year, authorized companies shall train their elevator mechanics who perform safety tests on safety test procedures.

**71.15(2)** For each conveyance owned by an authorized company, the owner shall obtain the services of a CEI who is not employed by the authorized company or an inspector employed by the state to witness the safety test.

**71.15(3)** To become authorized to perform safety tests, a company shall submit a copy of its procedures for performing safety tests. The labor commissioner shall review the procedures for adequacy and shall request modifications to the procedures or grant or deny the authorization.

**71.15(4)** Every five years or within six months after the board adopts a new edition of ASME, whichever is earlier, authorized companies shall submit revised safety test procedures for renewal of authorization. The labor commissioner shall review the procedures for adequacy and shall request modifications to the procedures or grant or deny the authorization.

**71.15(5) Investigations.** Investigations shall take place at the times and in the places the labor commissioner directs. The labor commissioner may investigate for any reasonable cause. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice.

**71.15(6) Suspension.** If the labor commissioner determines that a falsified safety test report was submitted by an elevator mechanic, the labor commissioner shall suspend the authorization of the

elevator mechanic's employer for six months. During the suspension, all safety tests performed by any employee of the authorized company shall be witnessed by a state inspector or a CEI who is not employed by the suspended authorized company.

**71.15(7) Suspension procedures.**

a. The labor commissioner shall notify an authorized company of its suspension by certified mail or by other service as permitted by Iowa Code chapter 17A.

b. The authorized company shall have 20 days to file a written notice of contest with the labor commissioner. If the authorized company does not file a written notice of contest in a timely manner, the suspension shall automatically be effective. If the authorized company does file a written notice of contest in a timely manner, the hearing procedures in 875—Chapter 1 shall govern.

c. If the labor commissioner finds, pursuant to Iowa Code section 17A.18A, that public health, safety or welfare imperatively requires emergency action, the authorization may be summarily suspended.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.16(89A) Fees.** Except as noted in this rule, all fees are nonrefundable and due in advance.

**71.16(1) Operating permits.** The annual operating permit fee shall be \$75 per conveyance.

**71.16(2) Periodic inspections.** Fees shall be remitted to the division of labor services within 30 days of the date of inspection. The fees for periodic inspections shall be as follows:

- a. Construction elevator: \$200.
- b. Wind tower lift: \$225.
- c. Hand-powered elevator: \$90.
- d. Television tower elevator: \$500.
- e. Handicapped restricted use elevator: \$100.
- f. Other hydraulic elevator: \$100.
- g. Other traction elevator: \$150.
- h. Escalator: \$150.
- i. Dumbwaiter: \$90.
- j. Wheelchair lift: \$90.
- k. CPH.
- (1) Annual: \$500.
- (2) Quarterly: \$200.
- l. Moving walk: \$150.

**71.16(3) Installation permits.** The fees in this subrule cover the initial print review, installation permit, initial inspection and first-year operating permit. Each print revision submitted to the division shall be subject to an additional fee of \$100. The fees for new installations shall be as follows:

- a. Wind tower lift: \$500.
- b. Material lift elevators: \$500.
- c. Other hydraulic elevators: \$750.
- d. Other traction elevators: \$1000.
- e. Escalator: \$1000.
- f. Dumbwaiter: \$500.
- g. Wheelchair lift: \$500.
- h. CPH: \$500.
- i. Moving walk: \$500.

**71.16(4) Alteration permits.**

a. Except as set forth below, the fee for any elevator alteration permit shall be \$500 and shall cover the initial print review, alteration permit, and initial inspection.

b. The fee for each CPH extension shall be \$150. The total fee required for all planned CPH extensions shall be submitted with the installation permit application pursuant to subrule 71.5(3).

c. The fee for an alteration permit shall be \$500 if the only alteration is the addition or replacement of an escalator skirt brush.

d. The fee for an initial print review, elevator alteration permit, and initial inspection shall be \$250 if both of the following conditions are met:

(1) The only changes covered by the elevator alteration permit application are required by ASME A17.3 (2011) as adopted in 875—Chapters 72 and 73; and

(2) The elevator alteration permit application is submitted before or no later than 120 days after the issuance of an inspection report describing ASME A17.3 requirements.

e. For all other conveyances, the fees for new installations shall apply to alterations.

**71.16(5) Construction permits.** The construction permit fee shall be \$200 per conveyance. This fee includes the fee for initial inspection.

**71.16(6) Controller upgrade permits.** The controller upgrade permit fee shall be \$250. This fee includes one inspection.

**71.16(7) Consultative inspections.** Consultative inspections may be performed at the discretion of the labor commissioner for \$125 per hour, including travel time, with a minimum charge of \$250.

**71.16(8) Special inspector commission.** The special inspector commission fee shall be \$60 annually.

**71.16(9) Witness of safety tests.** The fee for division employees to witness safety tests shall be \$125 per hour, including travel time, with a minimum charge of \$250.

**71.16(10) Permit extensions.** The fee to extend an installation permit, alteration permit, or construction permit shall be \$100.

**71.16(11) Inspections outside of normal business hours.** Inspections outside the normal business hours may be performed at the discretion of the labor commissioner. If the owner or contractor requests an inspection outside of normal business hours and the labor commissioner agrees to the schedule, an additional fee will be charged. The additional fee will be calculated at a rate of \$200 per hour, including travel time, with a minimum charge of \$400.

**71.16(12) Reinspections.** The fees for reinspections are \$400 for television tower elevators and CPHs, \$200 for wind tower lifts, and \$300 for all other conveyances.

**71.16(13) Inspection for temporary removal from service.** The inspection fee for temporary removal from service pursuant to rule 875—71.20(89A) shall be \$125 per hour, including travel time, with a minimum charge of \$250.

**71.16(14) Fee waiver.**

a. When a state inspector combines in one visit two different types of inspection on a single conveyance, the commissioner may waive the lesser of the fees.

b. The fee for an alteration permit shall be waived by the commissioner if the only alterations covered by the permit application are required by rule 875—72.26(89A) or 875—73.27(89A). The fee waiver set forth in this paragraph does not eliminate the requirement to pay for an acceptance inspection or for an operating permit.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 9221B, IAB 11/17/10, effective 12/22/10; ARC 0318C, IAB 9/5/12, effective 10/10/12; ARC 0685C, IAB 4/17/13, effective 5/22/13; ARC 1158C, IAB 10/30/13, effective 12/4/13; ARC 1972C, IAB 4/29/15, effective 6/3/15; ARC 1971C, IAB 4/29/15, effective 6/3/15; ARC 2603C, IAB 7/6/16, effective 8/10/16; ARC 4376C, IAB 3/27/19, effective 5/1/19]

**875—71.17(89A) Publications available for review.** Standards, codes, and publications adopted by reference in these rules are available for review in the office of the Division of Labor Services, 1000 E. Grand Avenue, Des Moines, Iowa 50319.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.18(89A) Other regulations affecting elevators.** Regulations concerning accessibility of buildings and conveyances available to the public are found at 661—Chapter 302. Regulations governing the safety and health of employees who work in and around elevators are found at 875—Chapters 2 to 26. Iowa Code chapter 91C and 875—Chapter 150 apply to companies that alter and install conveyances. No rule in 875—Chapters 71 to 73 shall be interpreted as creating an exemption, waiver, or variance from any otherwise applicable regulation or statute.

[ARC 7840B, IAB 6/17/09, effective 7/22/09]

**875—71.19(89A) Accidents and injuries.**

**71.19(1)** This rule applies to a conveyance in the event one of the following occurs:

- a. A personal injury accident that requires the service of a physician;
- b. A personal injury accident that causes disability exceeding one day; or
- c. Damage that will require more than one hour of mechanic's time (excluding travel) to repair.

**71.19(2)** The owner shall promptly notify the commissioner if one of the events listed in subrule 71.19(1) occurs. Notification shall be in writing and shall include the state identification number, owner, and description of accident.

**71.19(3)** The removal of any part of the damaged conveyance or operating mechanism from the premises is forbidden until permission is granted by the commissioner.

**71.19(4)** When an accident or injury involves the failure or destruction of any part of the conveyance or its operating mechanism, the use of the conveyance is forbidden until it has been inspected and approved by the commissioner.

[ARC 7840B, IAB 6/17/09, effective 7/22/09; ARC 3856C, IAB 6/20/18, effective 8/1/18]

**875—71.20(89A) Temporary removal from service.** The requirements for an annual inspection, annual inspection fee, safety test, operating permit, and operating permit fee shall be temporarily suspended for up to three years for an elevator in an unoccupied building if the requirements of this rule are met.

**71.20(1)** All elevator doors in unoccupied buildings shall be closed and locked. Hydraulic elevators shall be parked at the bottom of the hoistway. Traction elevators shall be parked at the top of the hoistway.

**71.20(2)** Upon request by the owner of an elevator in an unoccupied building, the labor commissioner shall send an inspector who is a state employee to confirm that the building is unoccupied and that the car and doors of the elevator have been properly secured. If the conditions set forth in subrule 71.20(1) are met, the inspector shall apply to the elevator a seal and a red tag marked with the words "Do Not Operate."

**71.20(3)** One year after the inspection, the owner must file with the labor commissioner written confirmation that the status of the elevator and building have not changed, and the owner must file again two years after the inspection. Failure to comply with this requirement shall result in termination of the temporary suspension of the requirements for safety tests, inspections, and operating permits.

**71.20(4)** Prior to returning the elevator to service, and upon request of the owner, the labor commissioner may allow the elevator to be operated for 30 days for the sole purpose of performing safety tests and maintenance.

**71.20(5)** The owner must notify the labor commissioner at least two weeks before placing an elevator back into service and must arrange for an inspector who is a state employee to witness a safety test.

**71.20(6)** If at the end of three years the building is still unoccupied, suspension of the requirements for safety tests, inspections, and operating permits shall end without possibility of renewal.

[ARC 0318C, IAB 9/5/12, effective 10/10/12]

These rules are intended to implement Iowa Code chapters 89A, 252J, and 272D.

[Filed emergency 12/15/75, Notice 10/6/75—published 12/29/75, effective 12/15/75]

[Filed 7/28/82, Notice 5/26/82—published 8/18/82, effective 9/30/82]

[Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]

[Filed emergency 12/4/92 after Notice 9/30/92—published 12/23/92, effective 12/23/92]

[Filed 2/15/01, Notice 10/18/00—published 3/7/01, effective 4/11/01]

[Filed 11/20/01, Notice 6/13/01—published 12/12/01, effective 1/16/02]

[Filed 11/7/03, Notice 10/1/03—published 11/26/03, effective 1/1/04]

[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]

[Filed 7/3/07, Notice 4/25/07—published 8/1/07, effective 9/5/07]

[Filed 1/25/08, Notice 11/7/07—published 2/13/08, effective 3/19/08]

[Filed emergency 5/28/08—published 6/18/08, effective 5/28/08]

[Filed 5/29/08, Notice 4/23/08—published 6/18/08, effective 7/23/08]

[Filed emergency 6/24/08—published 7/16/08, effective 7/23/08]

[Filed 9/3/08, Notice 6/18/08—published 9/24/08, effective 10/29/08]

[Filed 9/3/08, Notice 7/16/08—published 9/24/08, effective 10/29/08]  
[Filed ARC 7840B (Notice ARC 7696B, IAB 4/8/09), IAB 6/17/09, effective 7/22/09]  
[Filed ARC 7841B (Notice ARC 7697B, IAB 4/8/09), IAB 6/17/09, effective 7/22/09]  
[Filed ARC 9221B (Notice ARC 8996B, IAB 8/11/10), IAB 11/17/10, effective 12/22/10]  
[Filed ARC 0168C (Notice ARC 0011C, IAB 2/22/12), IAB 6/13/12, effective 7/18/12]  
[Filed ARC 0318C (Notice ARC 0171C, IAB 6/13/12), IAB 9/5/12, effective 10/10/12]  
[Filed ARC 0574C (Notice ARC 0411C, IAB 10/31/12), IAB 2/6/13, effective 3/13/13]  
[Filed ARC 0685C (Notice ARC 0597C, IAB 2/6/13), IAB 4/17/13, effective 5/22/13]  
[Filed ARC 1159C (Notice ARC 0951C, IAB 8/21/13), IAB 10/30/13, effective 12/4/13]  
[Filed ARC 1158C (Notice ARC 1009C, IAB 9/4/13), IAB 10/30/13, effective 12/4/13]  
[Filed ARC 1766C (Notice ARC 1560C, IAB 7/23/14), IAB 12/10/14, effective 1/14/15]  
[Filed ARC 1971C (Notice ARC 1849C, IAB 2/4/15), IAB 4/29/15, effective 6/3/15]  
[Filed ARC 1972C (Notice ARC 1853C, IAB 2/4/15), IAB 4/29/15, effective 6/3/15]  
[Filed ARC 2333C (Notice ARC 2163C, IAB 9/30/15), IAB 1/6/16, effective 2/10/16]  
[Filed ARC 2396C (Notice ARC 2264C, IAB 11/25/15), IAB 2/17/16, effective 3/23/16]  
[Filed ARC 2603C (Notice ARC 2355C, IAB 1/6/16), IAB 7/6/16, effective 8/10/16]  
[Filed ARC 2607C (Notice ARC 2422C, IAB 3/2/16), IAB 7/6/16, effective 8/10/16]  
[Filed ARC 3742C (Notice ARC 3503C, IAB 12/20/17), IAB 4/11/18, effective 5/16/18]  
[Filed ARC 3856C (Notice ARC 3727C, IAB 4/11/18), IAB 6/20/18, effective 8/1/18]  
[Filed ARC 4212C (Notice ARC 4088C, IAB 10/24/18), IAB 1/2/19, effective 3/1/19]  
[Filed ARC 4376C (Notice ARC 4237C, IAB 1/16/19), IAB 3/27/19, effective 5/1/19]  
[Filed ARC 5159C (Notice ARC 4940C, IAB 2/26/20), IAB 8/26/20, effective 9/30/20]



CHAPTER 90  
ADMINISTRATION OF THE BOILER AND PRESSURE VESSEL PROGRAM

[Prior to 1/14/98, see 347—Chs 41 to 49]

[Prior to 8/16/06, see 875—Chs 200, 202]

**875—90.1(89) Purpose and scope.** These rules institute administrative and operational procedures for implementation of Iowa Code chapter 89. An object shall not be considered “under pressure” and shall not be within the scope of Iowa Code chapter 89 when there is clear evidence that the manufacturer did not intend it to be operated at more than 3 psi and the object is operating at 3 psi or less. Jurisdiction is limited to objects, appurtenances, controls, safety devices, and equipment rooms as required by Iowa rules.

[ARC 0416C, IAB 10/31/12, effective 12/5/12; ARC 3903C, IAB 7/18/18, effective 9/1/18]

**875—90.2(89,252J,272D) Definitions.** To the extent they do not conflict with the definitions contained in Iowa Code chapter 89, the definitions in this rule shall be applicable to the rules contained in 875—Chapters 90 to 96.

“*Alteration*” means a change in a boiler or pressure vessel that substantially alters the original design requiring consideration of the effect of the change on the original design. It is not intended that the addition of nozzles smaller than an unreinforced opening size will be considered an alteration.

“*ANSI/ASME CSD-1*” means Control and Safety Devices for Automatically Fired Boilers.

“*Appurtenance*” means any item or equipment that is attached to the object and is part of the boiler external piping.

“*ASME*” means the American Society of Mechanical Engineers.

“*Boiler*” means a vessel in which water or other liquids are heated, steam or other vapors are generated, steam or other vapors are superheated, or any combination thereof, under pressure or vacuum by the direct application of heat. “Boiler” includes all temporary boilers.

“*Boiler external piping*” means all boiler piping and components as set forth in the scope of the edition of ASME B31.1 currently adopted by reference in Chapter 91.

“*Certificate of noncompliance*” means:

1. A certificate of noncompliance issued by the child support recovery unit, department of human services, pursuant to Iowa Code chapter 252J; or
2. A certificate of noncompliance issued by the centralized collection unit of the department of revenue pursuant to Iowa Code chapter 272D.

“*CFR*” means Code of Federal Regulations.

“*Construction or installation code*” means the applicable standard for construction or installation in effect at the time of installation.

“*Division*” means the division of labor services, unless another meaning is clear from the context.

“*Electric boilers*” means a power boiler, heating boiler, high or low temperature water boiler in which the source of heat is electricity.

“*External inspection*” means as complete an examination as can be reasonably made of the external surfaces and safety devices while the boiler or pressure vessel is in operation.

“*High temperature water boiler*” means a water boiler intended for operations at pressures in excess of 160 psig or temperatures in excess of 250 degrees F.

“*Hot water heating boiler*” means a boiler in which no steam is generated, from which hot water is circulated for heating purposes and then returned to the boiler, and which operates at a pressure not exceeding 160 psig or a temperature of 250 degrees F at the boiler outlet.

“*Hot water supply boiler*” means a boiler completely filled with water that furnishes hot water to be used externally to itself at pressures not exceeding 160 psig or at temperatures not exceeding 250 degrees F.

“*Institution of health and custodial care*” means any of the following:

1. A health care facility as defined by Iowa Code section 135C.1;
2. An assisted living program as defined by Iowa Code section 231C.2;
3. A boarding home as defined by Iowa Code section 135O.1;

4. A hospice that offers inpatient services in an institutional setting;
5. Any institution or facility in which persons are housed to receive medical, health, or other care or treatment; or
6. Any other institution or facility in which persons are housed to receive assistance with meeting personal needs or activities of daily living.

A facility or office that provides care and services only on an outpatient basis shall not be an “institution of health and custodial care.”

“*Internal inspection*” means as complete an examination as can be reasonably made of the internal and external surfaces of a boiler or pressure vessel while it is shut down and while manhole plates, handhole plates or other inspection opening closures are removed as required by the inspector.

“*ISO*” means International Standards Organization.

“*Labor commissioner*” means the labor commissioner or the commissioner’s designee.

“*Lap seam crack*” means a crack found in lap seams, extending parallel to the longitudinal joint and located either between or adjacent to rivet holes.

“*National Board*” means the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, Ohio 43229, whose membership is composed of the chief inspectors of jurisdictions who are charged with the enforcement of the provisions of boiler codes.

“*National Board Inspection Code*” means the Manual for Boiler and Pressure Vessel Inspectors (ANSI/NB 23) published by the National Board. Copies of the code may be obtained from the National Board.

“*Object*” means a boiler or pressure vessel.

“*Power boiler*” means a boiler in which steam or other vapor is generated at a pressure of more than 15 pounds per square inch or a water boiler intended for operation at pressures in excess of 160 pounds per square inch or temperatures in excess of 250 degrees Fahrenheit.

“*Process steam generator*” means a vessel or system of vessels comprised of one or more drums and one or more heat exchange surfaces as used in waste heat or heat recovery type steam boilers.

“*Psig*” means pounds per square inch gage.

“*Reinstallation*” means the process of disconnecting an object, moving it, and reconnecting it at the same location or a new location.

“*Relief valve*” means an automatic pressure-relieving device actuated by a static pressure upstream of the valve that opens further with the increase in pressure over the opening pressure and that is used primarily for liquid service.

“*Repair*” means work necessary to return a boiler or pressure vessel to a safe operating condition.

“*Rupture disk device*” means a nonreclosing pressure-relief device actuated by inlet static pressure and designed to function by the bursting of a pressure-containing disk.

“*Safety appliance*” shall include, but not be limited to:

1. Rupture disk device;
2. Safety relief valve;
3. Safety valve;
4. Temperature limit control;
5. Pressure limit control;
6. Gas switch;
7. Air switch; or
8. Any major gas train control.

“*Safety relief valve*” means an automatic, pressure-actuated relieving device suitable for use as a safety or relief valve, depending on application.

“*Safety valve*” means an automatic, pressure-relieving device actuated by the static pressure upstream of the valve and characterized by full opening pop action. The safety valve is used for gas or vapor service.

“*Special inspection*” means an inspection which is not required by Iowa Code chapter 89.

“*Temperature and pressure relief valve*” means a valve set to relieve at a designated temperature and pressure.



*“Unfired steam boiler”* means a vessel or system of vessels intended for operation at a pressure in excess of 15 psig for the purpose of producing and controlling an output of thermal energy.

*“Unfired steam pressure vessel”* means a vessel or container used for the containment of steam pressure either internal or external in which the pressure is obtained from an external source.

*“U.S. customary units”* means feet, pounds, inches and degrees Fahrenheit.

*“Water heater supply boiler”* means a closed vessel in which water is heated by combustion of fuels, electricity or any other source and withdrawn for use external to the system at pressure not exceeding 160 psig and shall include all controls and devices necessary to prevent water temperatures from exceeding 210 degrees F.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 9790B, IAB 10/5/11, effective 11/9/11; ARC 0319C, IAB 9/5/12, effective 10/10/12; ARC 0739C, IAB 5/15/13, effective 6/19/13; ARC 1964C, IAB 4/15/15, effective 5/20/15; ARC 3903C, IAB 7/18/18, effective 9/1/18; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—90.3(89) Iowa identification numbers.** All objects shall be identified by an Iowa identification number. State inspectors and special inspectors shall assign identification numbers as directed by the division to all jurisdictional objects that lack numbers. Identification numbers shall be attached in plain view to the object using one of the following methods:

1. A yellow sticker 2 inches by 3 inches affixed to the object and bearing the number.
2. A metal tag 1 inch by 2½ inches affixed to the object and bearing the number.
3. Numbers at least 5/16 of an inch high and stamped directly on the object.

**875—90.4(89) National Board registration.** Rescinded IAB 11/18/09, effective 1/1/10.

**875—90.5(89) Preinspection owner or user preparation.**

**90.5(1) Preparation of objects.** Each owner or user shall ensure that each object covered by Iowa Code chapter 89 is prepared for inspection pursuant to this rule.

**90.5(2) Confined space and lockout, tagout procedures.**

a. It is the responsibility of the owner or user to assess all objects for compliance with the confined space and lockout, tagout standards pursuant to 29 CFR 1910.146 and 1910.147. If an object is a non-permit-required confined space or a permit-required confined space as defined by 29 CFR 1910.146, the owner or user must comply with all applicable requirements of 29 CFR 1910.146 and 1910.147 in preparing the object for inspection.

b. It is the duty of the owner or user to inform any inspector of the owner's or user's confined space entry and lockout, tagout procedures and supply to the inspector all information necessary to assess whether the confined space is safe for entry. It is the right of an inspector to verify any of the information supplied.

c. If the requirements of 29 CFR 1910.146 and 1910.147 are not met, the inspector shall not enter the space. If there is a breach of the procedure or the procedure is inconsistent with 29 CFR 1910.146 or 1910.147, the inspection process shall cease until the space is reassessed and determined to be safe or the procedure is rewritten in a manner consistent with the standards. No inspector shall violate the owner's or user's confined space or lockout, tagout procedures in making an inspection.

d. The owner or user shall have all objects locked and tagged, as applicable, prior to the inspector's entry for inspection or testing.

e. For entry into a permit-required confined space, the owner or user shall provide the necessary equipment such as air monitors and a qualified attendant who has received all the information relevant to the entry.

**90.5(3) Hydrostatic tests.** The owner or user shall prepare for and apply a hydrostatic test, whenever necessary, on the date specified by the inspector, which date shall be not less than seven days after the date of notification.

**90.5(4) Boilers.** A boiler shall be prepared for internal inspection in the following manner:

- a. Fluid shall be drawn off and the boiler washed thoroughly.

b. Manhole and handhole plates, washout plugs and inspection plugs in water columns shall be removed as required by the inspector. The furnace and combustion chambers shall be thoroughly cooled and cleaned.

c. All grates of internally fired boilers shall be removed.

d. Brickwork shall be removed as required by the inspector in order to determine the condition of the boiler, header, furnace, supports or other parts.

e. Low-water fuel cutoff controls shall be opened or removed to allow for visual inspection.

**90.5(5) *Pressure vessels.*** The extent of inspection preparation for a pressure vessel will vary. If the inspection is to be external only, advance preparation is not required other than to afford reasonable access to the vessel. For combined internal and external inspections of small vessels of simple construction handling air, steam, nontoxic or nonexplosive gases or vapors, minor preparation is required, including affording reasonable means of access and removing manhole plates and inspection openings. In other cases, preparation shall include removing the internal fittings and appurtenances to permit satisfactory inspection of the interior of the vessel if required by the inspector.

**90.5(6) *Removal of covering or brickwork to permit inspection.*** If the object is jacketed so that the longitudinal seams of shells, drums, or domes cannot be seen, sufficient jacketing, setting wall, or other form of casing or housing shall be removed to permit reasonable inspection of the seams and so that the size of rivets, pitch of the rivets, and other data necessary to determine the safety of the object may be obtained, providing the information cannot be determined by other means. Brickwork shall be removed as required by the inspector in order to determine the condition of the boiler, header, furnace, supports or other parts.

**90.5(7) *Improper preparation for inspection.*** If an object has not been properly prepared for an internal inspection, or if the owner or user fails to comply with the requirements for hydrostatic tests as set forth in this chapter, the inspector may decline to make the inspection or test, and the inspection certificate shall be withheld until the owner or user complies with the requirements.

[ARC 9082B, IAB 9/22/10, effective 10/27/10]

## **875—90.6(89) Inspections.**

**90.6(1) *General.*** All boilers and unfired steam pressure vessels covered by Iowa Code chapter 89 shall be inspected according to the requirements of the National Board Inspection Code (2019), which is hereby adopted by reference. A division inspector or special inspector must perform the inspections.

### **90.6(2) *Schedule.***

a. All required inspections must be performed according to the schedule set forth in Iowa Code section 89.3, unless an exception is set forth in this rule.

b. Except for inspections of unfired steam pressure vessels operating in excess of 15 pounds per square inch and low pressure steam boilers, each certificate inspection must be performed within a 60-day period prior to the expiration date of the operating certificate. Modification of this 60-day period will be permitted only upon written application showing just cause for waiver of the 60-day period.

c. Special inspections may be conducted at any time mutually agreed to by the division and the object's owner or user.

**90.6(3) *Inspections conducted by special inspectors.*** Special inspectors shall provide copies of the completed report to the insured and to the division within 30 days of the inspection. The reports shall list all adverse conditions and all requirements, if any. If the special inspector has not notified the division of the inspection results within 30 days of the expiration of an operating certificate, the division may conduct the inspection.

**90.6(4) *Type of inspection.*** The inspection shall be an internal inspection when required; otherwise, it shall be as complete an external inspection as possible. Conditions including, but not limited to, the following may also be the basis for an internal inspection:

a. Visible metal or insulation discoloration due to excessive heat.

b. Visible distortion of any part of the pressure vessel.

c. Visible leakage from any pressure-containing boundary.

- d. Any operating records or verbal reports of a vessel being subjected to pressure above the nameplate rating or to a temperature above or below the nameplate design temperature.
- e. A suspected or known history of internal corrosion or erosion.
- f. Evidence or knowledge of a vessel having been subjected to external heat from a fire.
- g. A welded repair not documented as required.
- h. Evidence of an accident, incident or malfunction that could affect or may have resulted from a problem with the object's integrity.

**90.6(5)** *Internal inspections for unfired steam pressure vessels operating at more than 15 pounds per square inch.* The commissioner may require an internal inspection of an unfired steam pressure vessel operating in excess of 15 psi when an inspector observes any deviation from these rules, Iowa Code chapter 89, the construction code, the installation code, or the National Board Inspection Code.

**90.6(6)** *Inspection of inaccessible parts.* When, in the opinion of the inspector, as a result of conditions disclosed at the time of inspection, it is advisable to remove the interior or exterior lining, covering, or brickwork to expose certain parts of the vessel not normally visible, the owner or user shall remove such material to permit proper inspection and thickness measurement of any part of the vessel. Nondestructive examination is acceptable.

**90.6(7)** *Imminent danger.* If the labor commissioner determines that continued operation of an object constitutes an imminent danger that could seriously injure or cause death to any person, notice to immediately cease operation of that object shall be posted by the labor commissioner. Upon such notice, the owner shall immediately begin the necessary steps to cease operation of the object. The object shall not be used until the necessary repairs have been completed and the object has passed inspection. Operation of an object in violation of this subrule may result in further legal action pursuant to Iowa Code sections 89.11 and 89.13.

**90.6(8)** *Internal inspections on a four-year cycle based on process safety management compliance.* The owner shall demonstrate compliance with the requirements set forth in Iowa Code section 89.3(5)“a”(4)(b) by annually submitting to the labor commissioner a notarized affidavit. The affidavit shall be in a format approved by the labor commissioner and shall be signed by the owner or an officer of the company.

**90.6(9)** *Internal inspection on a four-year cycle for utility objects.* An object that meets the criteria of this subrule shall be inspected internally at least once every four years and externally every year. If at any time the object or the owner no longer meets the criteria of this subrule, internal inspections shall be performed on a two-year cycle.

a. The object is owned and operated by an electric public utility subject to rate regulation under Iowa Code chapter 476.

b. The object and the owner meet all the requirements for a two-year internal inspection interval as set forth in Iowa Code section 89.3, subsection 4.

c. If the object is shut down for a period sufficient to allow safe entry, and more than two years have passed since the last internal inspection, the owner shall notify the labor commissioner of the outage and shall schedule an internal inspection.

d. If the labor commissioner determines that an earlier inspection is necessary, the owner shall prepare the object for inspection pursuant to rule 875—90.5(89).

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 0319C, IAB 9/5/12, effective 10/10/12; ARC 1189C, IAB 11/27/13, effective 1/1/14; ARC 1634C, IAB 10/1/14, effective 11/5/14; ARC 1964C, IAB 4/15/15, effective 5/20/15; ARC 2403C, IAB 2/17/16, effective 4/1/16; ARC 4977C, IAB 3/11/20, effective 4/15/20]

## **875—90.7(89) Fees.**

**90.7(1)** *Special inspector commission fee.* A \$55 fee shall be paid annually to the commissioner to obtain a special inspector commission pursuant to Iowa Code section 89.7.

**90.7(2)** *Certificate fee.* A \$40 fee shall be paid for each one-year certificate, an \$80 fee shall be paid for each two-year certificate, and a \$160 fee shall be paid for each four-year certificate.

**90.7(3)** *Fees for inspection.* An inspection fee for each object inspected by a division inspector shall be paid by the appropriate party as follows:

- a. A \$55 fee for each water heater supply boiler.

b. A \$95 fee for each boiler, other than a water heater supply boiler, having a working pressure up to and including 450 pounds per square inch or generating between 20,000 and 100,000 pounds of steam per hour.

c. A \$215 fee for each boiler, other than a water heater supply boiler, having a working pressure in excess of 450 pounds per square inch and generating in excess of 100,000 pounds of steam per hour.

d. A \$55 fee for each pressure vessel, such as steam stills, tanks, jacket kettles, sterilizers and all other reservoirs having a working pressure of 15 pounds or more per square inch.

e. An additional fee will be charged if, upon the request of an owner or user, the labor commissioner agrees to any non-routine schedule for an inspection outside of normal business hours, a special inspection, or a site visit. The additional fee will be calculated at a rate of \$200 per hour, including travel time, with a minimum charge of \$400.

f. If a boiler or pressure vessel has to be reinspected, there shall be another inspection fee as specified above.

**90.7(4) Fees for attempted inspections.** A \$35 fee shall be charged for each attempt by a division inspector to conduct an inspection which is not completed through no fault of the division.

[ARC 7863B, IAB 6/17/09, effective 7/1/09; ARC 8081B, IAB 8/26/09, effective 9/30/09; ARC 0319C, IAB 9/5/12, effective 10/10/12; ARC 1422C, IAB 4/16/14, effective 5/21/14; ARC 4733C, IAB 10/23/19, effective 11/27/19]

**875—90.8(89) Certificate.** No boiler or pressure vessel shall be operated without a current, valid certificate to operate. A certificate to operate shall not be issued until the boiler or pressure vessel is in compliance with the applicable rules and all fees have been paid. The current certificate to operate or a copy of the current certificate to operate shall be conspicuously posted in the room where the object is installed.

[ARC 1964C, IAB 4/15/15, effective 5/20/15]

**875—90.9(89,252J,272D) Special inspector commissions.**

**90.9(1) Definition of “reputable insurance company.”** As used in this rule, “reputable insurance company” means a company recognized by the Iowa insurance division as a licensed insurer, a risk retention group, an alien surplus lines insurer, or a surplus lines insurer.

**90.9(2) Application.** A person applying for a commission shall complete, sign, and submit to the division with the required fee the form entitled “Application for Boiler and Pressure Vessel Special Inspector Commission” provided by the division. Additionally, the applicant shall submit a copy of the applicant’s current National Board work card with each application.

**90.9(3) Expiration.** The commission is for no more than one year and ceases when the special inspector leaves employment with the insurance company, or when the commission is suspended or revoked by the labor commissioner. Each commission shall expire no later than June 30 of each year.

**90.9(4) Changes.** The special inspector shall notify the division at the time any of the information on the form or attachments changes.

**90.9(5) Denials.** The labor commissioner may refuse to issue or renew a special inspector’s commission for failure to complete an application package, if the applicant or inspector does not hold a National Board commission, or for any reason listed in subrules 90.9(7) to 90.9(9).

**90.9(6) Investigations.** Investigations shall take place at the time and in the places the labor commissioner directs. The labor commissioner may investigate for any reasonable cause. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice.

**90.9(7) Reasons for probation.** The labor commissioner may issue a notice of commission probation when an investigation reasonably reveals that the special inspector does not represent a reputable insurance company or the special inspector filed inaccurate reports.

**90.9(8) Reasons for suspension.** The labor commissioner may issue a notice of commission suspension when an investigation reasonably reveals the following:

- a. The special inspector failed to submit and report inspections on a timely basis;
- b. The special inspector abused the special inspector’s authority;
- c. The special inspector misrepresented self as a state inspector or a state employee;

- d. The special inspector used commission authority for inappropriate personal gain;
- e. The special inspector failed to follow the division's rules for inspection of object repairs, alterations, construction, installation, or in-service inspection;
- f. The special inspector committed numerous violations as described in subrule 90.9(7);
- g. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;
- h. The National Board revoked or suspended the special inspector's work card;
- i. The division received a certificate of noncompliance;
- j. The special inspector failed to take appropriate disciplinary actions against a subordinate special inspector who has committed repeated acts or omissions listed in paragraphs "a" to "h" of this subrule; or

k. The special inspector does not represent a reputable insurance company.

**90.9(9) Reasons for revocation.** The labor commissioner may issue a notice of revocation of a special inspector's commission when an investigation reveals any of the following:

- a. The special inspector filed a misleading, false or fraudulent report;
- b. The special inspector failed to perform a required inspection;
- c. The special inspector failed to file a report or filed a report which was not in accordance with the provisions of applicable standards;
- d. The special inspector failed to notify the division in writing of any accident involving an object;
- e. The special inspector committed repeated violations as described in subrule 90.9(8);
- f. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;
- g. The special inspector instructed, ordered, or otherwise encouraged a subordinate special inspector to perform the acts or omissions listed in paragraphs "a" to "f" of this subrule;
- h. The National Board revoked or suspended the special inspector's work card;
- i. The division received a certificate of noncompliance; or
- j. The special inspector does not represent a reputable insurance company.

**90.9(10) Procedures.** The following procedures shall apply except in the event of revocation or suspension due to receipt of a certificate of noncompliance. In instances involving receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J or 272D shall apply.

a. *Notice of actions.* The labor commissioner shall serve a notice on the special inspector by certified mail to an address listed on the commission application form or by other service as permitted by Iowa Code chapter 17A. A copy shall be sent to the insurance company employing the special inspector.

b. *Contested cases.* The special inspector shall have 20 days to file a written notice of contest with the labor commissioner. If the special inspector does not file a written contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.

c. *Hearing procedures.* The hearing procedures in 875—Chapter 1 shall govern.

d. *Emergency suspension.* Pursuant to Iowa Code section 17A.18A, if the labor commissioner finds that public health, safety or welfare imperatively requires emergency action because a special inspector failed to comply with applicable laws or rules, the special inspector's commission may be summarily suspended.

e. *Probation period.* A special inspector may be placed on probation for a period not to exceed one year for each incident causing probation.

f. *Suspension period.* A special inspector's commission may be suspended up to five years for each incident causing a suspension.

g. *Revocation period.* A special inspector's commission that has been revoked shall not be reinstated for five years.

h. *Concurrent actions.* Multiple actions may proceed at the same time against any special inspector.

*i. Revoked or suspended commissions.* Within five business days of final agency action revoking or suspending a special inspector commission, the special inspector shall forfeit the special inspector's commission card to the labor commissioner.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 4734C, IAB 10/23/19, effective 11/27/19; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—90.10(89) Quality reviews, surveys and audits.**

**90.10(1)** An entity that manufactures or repairs boilers, pressure vessels or related equipment may request quality reviews, surveys or audits from certifying organizations such as the ASME or the National Board. The division is authorized to conduct the quality reviews, surveys or audits. If the division performs the service, the manufacturer or repairer shall pay all applicable expenses.

**90.10(2)** Quality reviews, surveys and audits for certification to the National Board or ASME standards shall be conducted only by a person or organization designated by the labor commissioner. Any person or organization seeking this designation on behalf of the division shall provide documented evidence of training, examination, experience, and certification for the type of reviews, surveys and audits to be performed. The labor commissioner shall have final authority to determine qualifications and designations.

*a. Assessing quality programs.* The division recognizes the ASME and the National Board as qualified designees for conducting quality reviews, surveys and audits that lead to ASME or National Board program certification.

*b. ISO 9000 assessments.* The division recognizes the ASME and the National Board:

(1) To be acceptable ISO 9000 registrars of quality systems for boilers and pressure vessels and the related pressure-technology equipment industry;

(2) To certify auditors and lead auditors to the requirements of ISO 10011-2 1991(E), Annex A; and

(3) To conduct ISO 9000 assessments for the boiler, pressure vessel, and related pressure-technology equipment industry.

**875—90.11(89) Reporting requirements.**

**90.11(1) Control and safety device reports.** Documentation required by this subrule shall be kept on site and shall be available for inspection.

*a.* The requirements of this subrule do not apply to:

(1) Rescinded IAB 7/18/18, effective 9/1/18.

(2) An object within the scope of 875—Chapter 96;

(3) A hot water supply boiler covered by ASME Section IV, Part HLW; or

(4) A boiler with a fuel input rating greater than or equal to 12,500,000 Btu per hour, falling within the scope of NFPA 85, Boiler and Combustion Systems Hazards Code.

*b.* The installer shall complete a Manufacturer's/Installing Contractor's Report for ASME CSD-1 (CSD-1 report) for each newly installed or reinstalled object.

*c.* A person who installs a new burner, new gas train, or new controller on an object shall complete a CSD-1 report.

*d.* A person who replaces a part or component of an object shall complete the relevant portions of the CSD-1 report unless the replacement satisfies the design specifications. A copy of an invoice containing the same information as the relevant portions of the CSD-1 report is an acceptable alternative.

**90.11(2) Reporting repairs and alterations.** If the National Board Inspection Code requires that an R-1 Report of Repair or an R-2 Report of Alteration be filed with the National Board, a copy of the National Board form must be simultaneously filed with the labor commissioner.

**90.11(3) Reporting explosions and other incidents.**

*a.* The following definitions apply to this subrule.

*"Incident"* means the explosion of a covered object or other failure of a component of a covered object causing injury or acute illness.

*"Injury"* means a personal injury requiring professional medical care or causing disability exceeding one day.

b. The owner or user of a covered object shall notify the commissioner of an incident. A special inspector investigating an incident shall notify the owner or user of this reporting requirement.

c. Incident reports shall be made by calling (515)725-5609 or (515)725-5610. If the incident occurs during normal division operating hours, notification shall occur before close of business on that day. If the incident occurs when the division office is closed, the notification shall occur no later than close of business on the next division business day. Division hours are 8 a.m. to 4:30 p.m., Monday through Friday, except state holidays.

d. At the request of the commissioner, a person who submits a report pursuant to this subrule shall also submit a written report that includes the state identification number of the object, name of the owner of the object, and description of the incident.

e. The removal of any part of the damaged object from the premises is forbidden until permission to do so is granted by the state inspector or special inspector who investigated the incident.

f. When an incident involves the failure or destruction of any part of the object, the use of the object is forbidden until it has been made safe and it has passed an inspection by the state inspector or special inspector who investigated the incident.

[ARC 2589C, IAB 6/22/16, effective 7/27/16; ARC 3903C, IAB 7/18/18, effective 9/1/18; ARC 4733C, IAB 10/23/19, effective 11/27/19]

**875—90.12(89) Publications available for review.** Pursuant to Iowa Code section 89.5, subsection 3, the standards, codes, and publications adopted by reference in these rules are available for review in the office of the Division of Labor Services, 1000 East Grand Avenue, Des Moines, Iowa.

**875—90.13(89) Notice prior to installation.** Written notice of intent to install objects subject to the jurisdiction of Iowa Code chapter 89 shall be provided to the labor commissioner at least ten days before installation. Written notice shall be accomplished by completing and submitting to the labor commissioner either:

1. The form designated by the labor commissioner, or
2. The National Board's Boiler Installation Report, I-1.

**875—90.14(89) Temporary boilers.** A certificate to operate a temporary boiler shall expire one year from the date of issuance or when the temporary boiler is disconnected. Inspections on temporary boilers that remain in one location longer than one year shall be performed according to the inspection schedule of Iowa Code section 89.3. A temporary boiler that is installed at a different location less than a year since the prior internal inspection of the boiler shall be subjected to a hydrostatic test pursuant to the National Board Inspection Code or to an internal inspection, at the discretion of the inspector.

**875—90.15(89) Conversion of a power boiler to a low-pressure boiler.** The following requirements apply to the conversion of a power boiler to a low-pressure boiler. The owner shall comply with the requirements of subrule 90.15(1) for each conversion. In addition, the owner shall comply with the requirements of subrule 90.15(2) if the converted object will be located outside of a place of public assembly or with the requirements of subrule 90.15(3) if the converted object will be located in a place of public assembly.

**90.15(1) General requirements.**

a. The owner shall provide to the labor commissioner written notice of intent to convert a power boiler to a low-pressure boiler prior to conversion. The required form for a notice of conversion is available at [iowaboilers.gov](http://iowaboilers.gov). At a minimum the notice shall contain the following:

- (1) Address, uses, and owner of the building where the boiler is located.
- (2) The Iowa identification number assigned to the boiler.
- (3) Name and contact information for the person completing the notice.
- (4) Name and contact information for the contractor or other person planning to perform the conversion.

b. Pressure controls shall not exceed 14 pounds per square inch.

c. All boiler controls shall comply with ASME CSD-1.

*d.* Safety valves and safety relief valves shall be manufactured in accordance with a national or international standard.

*e.* One or more spring-pop safety valves meeting the following requirements shall be installed on each steam boiler:

- (1) The valve shall be adjusted and sealed to discharge at a pressure not to exceed 15 psig.
- (2) The valve capacity shall be certified by the National Board.

*f.* The converted boiler shall be subject to post-conversion external inspection to ensure that the requirements of this rule are met.

**90.15(2)** *Boilers located outside places of public assembly.* A power boiler that was converted to a low-pressure boiler and that is located outside of a place of public assembly shall not be converted back to a power boiler unless the following requirements are met:

- a.* The owner shall notify the labor commissioner at least ten days prior to converting the boiler.
- b.* The owner shall comply with the editions of ASME Section I and CSD-1 in effect at the time of the second conversion.
- c.* The owner shall comply with the version of 875—Chapter 92 in effect at the time of the second conversion.

**90.15(3)** *Boilers located in places of public assembly.* A power boiler converted to a low-pressure boiler that is located in a place of public assembly shall comply with 875—Chapter 94.

[ARC 9232B, IAB 11/17/10, effective 12/22/10; ARC 3635C, IAB 2/14/18, effective 3/21/18]

These rules are intended to implement Iowa Code chapters 17A, 89, 252J, and 272D.

[Filed emergency 12/26/97 after Notice 11/19/97—published 1/14/98, effective 1/1/98]

[Filed emergency 5/4/99 after Notice 3/24/99—published 6/2/99, effective 7/1/99]

[Filed 3/14/01, Notice 1/24/01—published 4/4/01, effective 5/9/01]

[Filed 7/29/05, Notice 6/8/05—published 8/17/05, effective 9/21/05]

[Filed emergency 9/6/05—published 9/28/05, effective 9/21/05]

[Filed 7/26/06, Notice 5/10/06—published 8/16/06, effective 9/20/06]<sup>◇</sup>

[Filed 11/30/07, Notice 10/24/07—published 12/19/07, effective 1/23/08]

[Filed 2/19/08, Notice 12/19/07—published 3/12/08, effective 4/16/08]<sup>1</sup>

[Filed Emergency ARC 7863B, IAB 6/17/09, effective 7/1/09]

[Filed ARC 8081B (Notice ARC 7865B, IAB 6/17/09), IAB 8/26/09, effective 9/30/09]

[Filed ARC 8283B (Notice ARC 8082B, IAB 8/26/09), IAB 11/18/09, effective 1/1/10]

[Filed ARC 9082B (Notice ARC 8694B, IAB 4/21/10), IAB 9/22/10, effective 10/27/10]

[Filed ARC 9232B (Notice ARC 9087B, IAB 9/22/10), IAB 11/17/10, effective 12/22/10]

[Filed ARC 9790B (Notice ARC 9511B, IAB 5/18/11), IAB 10/5/11, effective 11/9/11]

[Filed ARC 0319C (Notice ARC 0207C, IAB 7/11/12), IAB 9/5/12, effective 10/10/12]

[Filed ARC 0416C (Notice ARC 0322C, IAB 9/5/12), IAB 10/31/12, effective 12/5/12]

[Filed ARC 0739C (Notice ARC 0647C, IAB 3/20/13), IAB 5/15/13, effective 6/19/13]

[Filed ARC 1189C (Notice ARC 1015C, IAB 9/18/13), IAB 11/27/13, effective 1/1/14]

[Filed ARC 1422C (Notice ARC 1333C, IAB 2/19/14), IAB 4/16/14, effective 5/21/14]

[Filed ARC 1634C (Notice ARC 1550C, IAB 7/23/14), IAB 10/1/14, effective 11/5/14]

[Filed ARC 1964C (Notice ARC 1798C, IAB 12/24/14), IAB 4/15/15, effective 5/20/15]

[Filed ARC 2403C (Notice ARC 2251C, IAB 11/25/15), IAB 2/17/16, effective 4/1/16]

[Filed ARC 2589C (Notice ARC 2419C, IAB 2/17/16), IAB 6/22/16, effective 7/27/16]

[Filed ARC 3635C (Notice ARC 3504C, IAB 12/20/17), IAB 2/14/18, effective 3/21/18]

[Filed ARC 3903C (Notice ARC 3807C, IAB 5/23/18), IAB 7/18/18, effective 9/1/18]

[Filed ARC 4733C (Notice ARC 4564C, IAB 7/31/19), IAB 10/23/19, effective 11/27/19]

[Filed ARC 4734C (Notice ARC 4565C, IAB 7/31/19), IAB 10/23/19, effective 11/27/19]

[Filed ARC 4977C (Notice ARC 4863C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

[Filed ARC 5159C (Notice ARC 4940C, IAB 2/26/20), IAB 8/26/20, effective 9/30/20]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> Date corrected IAC Supp. 3/26/08



CHAPTER 155  
ASBESTOS REMOVAL AND ENCAPSULATION  
[Prior to 10/18/00, see 875—Chs 81 and 82]

**875—155.1(88B) Definitions.**

*“Business entity”* means a partnership, firm, association, corporation, sole proprietorship, or other business concern. A business entity that uses its own employees in removing or encapsulating asbestos for the purpose of renovating, maintaining or repairing its own facilities is not included.

*“Contractor/supervisor”* means a person who supervises workers on asbestos projects or a person who enters into contracts to perform asbestos projects and personally completes the work.

*“Division”* means the division of labor services.

*“Friable asbestos material”* means any material containing more than 1 percent asbestos by weight and that can be crumbled, pulverized, or reduced to powder by hand pressure when dry.

*“Inspector”* means a person who inspects for asbestos-containing building materials in a school or a public or commercial building.

*“License”* means an authorization issued by the division permitting an individual to be employed as a worker, contractor/supervisor, inspector, management planner, or project designer.

*“Management planner”* means a person who prepares asbestos management plans for a school building.

*“Permit”* means an authorization issued by the division permitting a business entity to remove or encapsulate asbestos.

*“Project designer”* means a person who designs asbestos response or maintenance projects for a school or a public or commercial building.

*“Worker”* means a person who performs response or maintenance activities on one or more asbestos projects.

*“Working days”* means Monday through Friday including holidays that fall on Monday through Friday. The first working day shall be the date of actual delivery or the postmark date, whichever is earlier. However, documents with Saturday or Sunday postmark dates will be treated as though postmarked on the following Monday.

[ARC 4639C, IAB 8/28/19, effective 10/2/19]

**875—155.2(88B) Permit application procedures.**

**155.2(1) Application.** To apply for or to renew a permit, a business entity shall complete and submit the form provided by the division. All requested applicable information and attachments must be provided. A \$500 nonrefundable application fee shall accompany each permit application.

**155.2(2) Action on application.** A new permit shall be valid for one year from the date of issuance. A renewal permit shall be valid for one year from the expiration date of the applicant’s prior permit. A permit may be denied for the reasons set forth in rule 875—155.8(17A,88B,252J,272D) or if the application package is incomplete. Within 60 days of receiving a completed application package for a new permit, the division will issue a permit or deny the application. Within 30 days of receiving a completed application package for a permit renewal, the division will issue a permit or deny the application. Applications received after expiration of a prior permit will be considered applications for new permits rather than renewals.

[ARC 4639C, IAB 8/28/19, effective 10/2/19; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—155.3(88B) Other asbestos regulations.** Regulation of encapsulation, removal and abatement procedures are found in 875—Chapters 10 and 26 and 567—Chapter 23. Nothing in this chapter shall be viewed as providing an exemption, waiver, or variance from any otherwise applicable regulation or statute.

**875—155.4(88B) Asbestos project records.** In addition to meeting requirements set forth in the occupational safety and health standards of 29 CFR 1910.1020, the permittee shall keep a record of

each asbestos project it performs and shall make the record available to the division at any reasonable time. Records required by this rule shall be kept for at least six years. The records shall include:

**155.4(1)** The name, address, and license number of the individual who supervised the asbestos project and of each employee or agent who worked on the project.

**155.4(2)** The location and a description of the project and the amount of asbestos material that was removed.

**155.4(3)** The start and completion dates of each instance of removal or encapsulation.

**155.4(4)** A summary of the procedures that were used to comply with all applicable standards.

**155.4(5)** The name and address of each asbestos disposal site where the asbestos-containing waste was deposited.

**155.4(6)** A receipt from the asbestos disposal site indicating the amount of asbestos and disposal date.

**155.4(7) to 155.4(9)** Rescinded IAB 8/28/19, effective 10/2/19.

[ARC 4639C, IAB 8/28/19, effective 10/2/19]

### **875—155.5(88B) Ten-day notices.**

**155.5(1) General.** Permittees shall notify the division at least ten working days before an asbestos project begins. A project begins when site preparations for asbestos abatement, encapsulation, or removal begin; when asbestos abatement, encapsulation, or removal begins; or when any demolition begins, whichever is sooner. Legible electronic transmissions of ten-day notices in the proper format shall be accepted.

**155.5(2) Emergency.** When there is an immediate danger to life, health or property, the permittee may file the notice within five days after beginning the project. An explanation of the emergency must be included.

**155.5(3) Format.** The notice shall be on an 8½" by 11" sheet of paper and shall contain the following information:

*a.* The name, address, and telephone number of and contact person for the permittee performing the project.

*b.* The name, address, and telephone number of the project.

*c.* A description of the structure and work to be performed, including type and quantity of asbestos-containing material.

*d.* The scheduled dates of the project's start and end.

*e.* Designation of the asbestos disposal site.

*f.* The signature and printed name of the person who completed the form.

*g.* The shift or work schedule on which the project will be performed.

**155.5(4) Disaster emergency proclamations.** For structures that are both located in an area that is subject to a disaster emergency proclamation pursuant to Iowa Code section 29C.6 and damaged by circumstances related to those that caused the disaster emergency proclamation, the permittee shall file the notice described by this rule as early as possible, but not later than the working day following the initiation of the project.

[ARC 4639C, IAB 8/28/19, effective 10/2/19]

### **875—155.6(88B) License application procedures.**

**155.6(1) Application form.** Except as noted in this subrule, the applicant must complete and submit the entire form provided by the division with the necessary attachments. Respirator fit tests and medical examinations must have occurred within the past 12 months. Only worker and contractor/supervisor license applicants must submit the respiratory protection and physician's certification forms. Photocopies of the forms shall not be accepted.

**155.6(2) Training.** A certificate of appropriate training as established by the U.S. Environmental Protection Agency must accompany all applications. Applicants for a license must be trained by training providers other than themselves. Applicants who completed initial training under a prior set of applicable rules will not be required to take another initial training course if they complete all annual refresher courses.

**155.6(3) Photographs.** Two 1" by 1" photographs clearly showing the applicant's face shall accompany all license applications.

**155.6(4) Worker licenses.** All persons seeking a license as an asbestos abatement worker shall complete an initial four-day training course and thereafter complete an annual one-day asbestos abatement worker refresher training course. A nonrefundable fee of \$20 shall accompany the application.

**155.6(5) Contractor/supervisor licenses.** All persons seeking a license as an asbestos abatement contractor/supervisor shall complete an initial five-day training course and thereafter complete an annual one-day asbestos abatement contractor/supervisor refresher training course. A nonrefundable fee of \$50 shall accompany the application.

**155.6(6) Inspector licenses.** All persons seeking a license as an asbestos inspector shall complete an initial three-day training course and thereafter complete an annual one-half-day asbestos inspector refresher training course. A nonrefundable fee of \$20 shall accompany the application.

**155.6(7) Management planner licenses.** All persons seeking a license as an asbestos management planner shall complete an initial three-day inspector training course and an initial two-day management planning training course. Thereafter, an annual one-half-day asbestos inspector refresher training course plus an additional one-half-day course on management planning are required. A nonrefundable fee of \$20 shall accompany the application.

**155.6(8) Abatement project designer licenses.** All persons seeking a license as an asbestos abatement project designer shall complete an initial three-day abatement project designer training course. Thereafter, an annual one-day asbestos abatement project designer refresher training course is required. A nonrefundable fee of \$50 shall accompany the application.

**155.6(9) Action on application.** Within 30 days of receiving a completed application, the division will issue a license or deny the application. If a license is issued, it will expire one year from the date the training was completed. An application may be denied for the reasons set forth in rule 875—155.8(17A,88B,252J,272D) or if the application package is incomplete.

**155.6(10) License on job site.** While conducting asbestos work that requires a license, the license or a legible copy of the license shall be in the licensee's possession at the work site. However, if the division of labor services' website reflects that a license has been issued to a particular person, that person may perform work consistent with the type of license issued without the license or a copy of the license for up to 14 days from the issuance date.

**155.6(11) Disaster emergency proclamations.** For work on structures that are both located in an area that is subject to a disaster emergency proclamation pursuant to Iowa Code section 29C.6 and damaged by circumstances related to those that caused the disaster emergency proclamation, the labor commissioner deems an individual to be licensed and authorized for asbestos abatement if all of the criteria in either paragraph "a" or paragraph "b" are met:

*a.* The individual contractor, supervisor, or worker makes the following immediately available on the work site:

(1) A copy of a certificate for training that was provided within the past 12 months as established by the U.S. Environmental Protection Agency and that pertains to the work being performed;

(2) A copy of a physician's statement indicating that, consistent with 29 CFR 1910.134, a licensed physician has examined the individual within the past 12 months and approved the individual to work while wearing a respirator;

(3) For a worker wearing or intending to wear a tight-fitting respirator, documentation of a respirator fit test consistent with 29 CFR 1910.134 within the past 12 months;

(4) A valid, current asbestos license issued by another state that pertains to the type of work being performed; and

(5) A photo identification card; or

*b.* The individual working as a project designer, inspector, or management planner makes the following immediately available on the work site:

(1) A copy of a certificate for training as established by the U.S. Environmental Protection Agency and that pertains to the work being performed;

(2) A valid, current asbestos license issued by another state that pertains to the type of work being performed; and

(3) A photo identification card.

[ARC 4639C, IAB 8/28/19, effective 10/2/19; ARC 5022C, IAB 4/8/20, effective 5/13/20; ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—155.7(88B) Duplicate permits and licenses.** Duplicate original permits and licenses are available from the division for a \$10 fee.

**875—155.8(17A,88B,252J,272D) Denial, suspension and revocation.**

**155.8(1) Grounds.** The division may deny an application or suspend or revoke a permit or license when an investigation reasonably determines any of the following:

- a. Fraud or deception was utilized in obtaining or attempting to obtain a permit or license.
- b. The qualifications for a permit or license are not met.
- c. Any applicable federal or state standard for removal or encapsulation of asbestos was violated.
- d. An unlicensed or untrained person was employed or allowed to work on an asbestos project.
- e. The division received a certificate of noncompliance from the centralized collection unit of the department of revenue or the child support recovery unit of the department of human services.
- f. Penalties or other debts are owed by the applicant to the division and are 30 days or more in arrears.

**155.8(2) Relinquishing license or permit.** A licensee or permittee must return the original license or permit to the division when a revocation or suspension becomes final.

**155.8(3) Suspension period.** Unless ordered otherwise, a suspension shall last for 12 months.  
[ARC 5159C, IAB 8/26/20, effective 9/30/20]

**875—155.9(17A,88B) Contested cases.**

**155.9(1) Scope.** This rule applies to civil penalty assessments and to denials, revocations and suspensions of asbestos licenses and permits.

**155.9(2) Procedures.** The labor commissioner shall serve a notice of intended action by restricted certified mail, return receipt requested, or by other service as permitted by Iowa Code section 17A.18. A notice of contest must be received by the labor commissioner within 20 days after service of the notice of intended action. If a notice of contest is not timely filed, the action stated in the notice of intended action shall automatically be effective. Hearing procedures for asbestos contested cases are set forth in 875—Chapter 1, Division V. However, if a contested case is based on receipt by the division of a certificate of noncompliance, procedures outlined in Iowa Code chapter 252J or 272D shall apply.

[ARC 5159C, IAB 8/26/20, effective 9/30/20]

These rules are intended to implement Iowa Code chapters 17A, 88B, 252J, and 272D.

[Filed 3/22/85, Notice 11/7/84—published 4/10/85, effective 5/15/85]<sup>1</sup>

[Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]

[Filed emergency 4/17/87—published 5/6/87, effective 4/17/87]

[Filed 4/27/88, Notice 12/30/87—published 5/18/88, effective 7/1/88]

[Filed 7/8/88, Notice 5/18/88—published 7/27/88, effective 9/1/88]

[Filed 3/17/89, Notice 9/21/88—published 4/5/89, effective 5/10/89]

[Filed emergency 5/25/89—published 6/14/89, effective 7/1/89]

[Filed 10/26/89, Notice 6/14/89—published 11/15/89, effective 12/29/89]

[Filed 4/19/91, Notices 12/26/90, 1/23/91—published 5/15/91, effective 6/19/91]

[Filed 9/19/00, Notice 3/22/00—published 10/18/00, effective 11/22/00]

[Filed 11/20/01, Notice 6/13/01—published 12/12/01, effective 1/16/02]

[Filed 11/30/06, Notice 7/19/06—published 12/20/06, effective 1/24/07]

[Filed 4/16/07, Notice 2/28/07—published 5/9/07, effective 6/13/07]

[Filed emergency 6/25/08—published 7/16/08, effective 6/25/08]

[Filed ARC 4639C (Notice ARC 4497C, IAB 6/19/19), IAB 8/28/19, effective 10/2/19]

[Filed ARC 5022C (Notice ARC 4894C, IAB 2/12/20), IAB 4/8/20, effective 5/13/20]

[Filed ARC 5159C (Notice ARC 4940C, IAB 2/26/20), IAB 8/26/20, effective 9/30/20]

- <sup>1</sup> Effective date of Ch 81 delayed seventy days by the Administrative Rules Review Committee.  
Exception: See rule 82.11(88B).  
Effective date of Ch 82 delayed seventy days by the Administrative Rules Review Committee, IAB 6/5/85.  
Effective date (5/15/85) of 82.3(1)“a”(11) delayed by the Administrative Rules Review Committee until the expiration of forty-five calendar days into the 1986 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 7/31/85.